Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Vaar Juanito Paje December 17, 2000 10:40 AM 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Ft. Washington Ft. Washington Medical Center Prince George's If Undar 1 Yaar If Undar 24 Hrs.

Months Days Hours Min. Birthplaca (Stete or Foreign Country) 5. Social Sacurity Number 8. Data of Birth (Month, Dey, Year) 7. Aga (In vrs. lest birthday) Months 1 M 2 □ F 212-44-7868 63 2-27-1936 Philippine Island Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Insida City Limits XX Yas 2 □ No Maryland Prince George's Oxon Hill 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number 20745 IISA 14. Race - Amaricen Indian, Black, Whita, atc.

20745

Approximata Intarval Batween Onsat and Death

1 ☐ Yas 2 No

29d. Data signed (Month, Dey, Year)

December 18, 2000

the Marylend r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at With death filed within 72 hours after Baltimore, Maryland 21215-0020 Hygiene. permit. Pages 1 and 2 should be filled w Depertment of Health end Mentei Hygier important: if frem 27 is marked other th any injury or other traumetic event, the

**Physician** 

Examiner

10a. Stata

**Funeral** 

Director

/Medical

Physician /Medical Examiner

the buriei-tran attending physiclan 88 950 for ed by the a been signed by should be detec certificate has page 2 funeral director, After this

edicai

State

Registrar

29a. Cartifier

29b. Signatura an of certifiar

31. Data filad (Month, Dey, Year)

DEC 1 9 2000

Division of Vital Records, P.O. Box 68760 certificate be or Attending Physician: efter death. in by To the Hospital of within 24 hours e To the Funeral D

Directo 1209 Westfield Drive Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 12. Was Dacedant Evar in U.S. Armed Forcas? Retired 1 10 Yes 2 10 No 1 Mas, Giva Year or Datas: 8/31/80 11. Marital Status 1 Navar Marriad 2X Marriad 1 ☐ Yes 2 No Specify þ Specify: Filipino 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Specify only highest grade complated) Elementery/Secondary (0-12) College (1-4or 5+) White House 12 Chef 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Be Nemesio Paje Magdalena Paranada 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Numbar or Rural Route Number, City or Town, Stete, Zip Code) 1209 Westfield Drive Oxon Hill, Maryland Ann C. Paje - Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) Data 20c. Locetlon - City or Town, Stata 20a. Mathod of Disposition 1) Buria! 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) -27-00Arlington National Cemetery Arlington, Virginia 22. Nama and Addrass of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service 6160 Oxon Hill Road, Oxon Hill, Maryland 20745 art1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Immediate Causa (Final Anoxic Encephalopathy disaasa or condition rasulting in deeth) Due to (or as e consequance of): Examiner Cardiac Arrest Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaase or Injury that initiated avants rasulting in daath) Last Dua to (or as a consaquance of): Metastatic Lung Cancer Physician/Medicai Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yas 2 ☐ No 3 □ Probably 4 Unknown Š 24a. Was an autopsy parformed? 24b. Wera autopsy findings availabla prior to complation of ceusa of death? Completed 1 ☐ Yas 2 ☐ No 25. Was case rafarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatiant 3 DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) OL 1 Yas 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Daath 28b. Tima of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding 1 Netural 1 ☐ Yas 2 ☐ No investigation 2 Accidant 6 Could not ba determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicida

30. Name and address of person who completed caluse of death (Itam 23a) (Typa, Print)

Edgar V. Potter, MD 1328 Southern Avenue S.E. Washington, D.C. 20032

and manner stated.

Ragistrar's Signatura

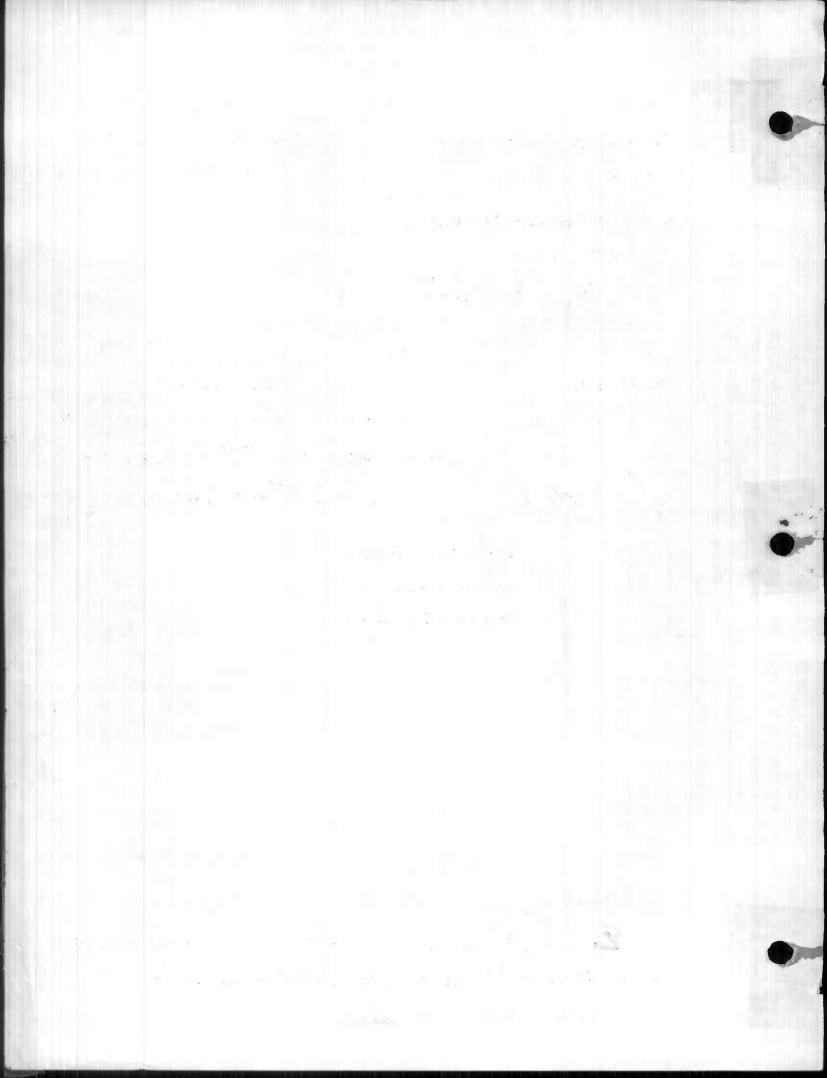
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Sporker

29c. Licansa numbar

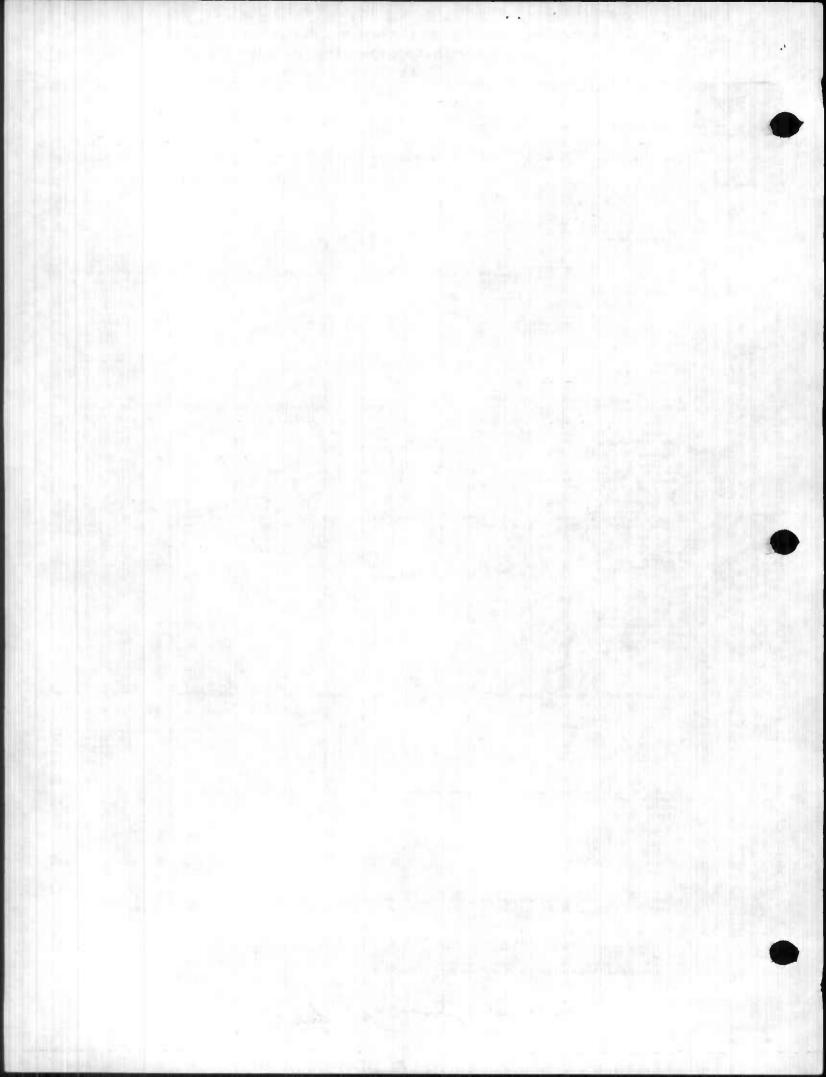
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State of Maryland / Department of Health and Mental Hygiene 0 4 2 5 0 2

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J.	Examiner									
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	Funeral	5. Social Security Number 6. Se	TYM all E	Month	der 1 Yaar hs Deys	Hours Min.	. (Month, Da	y, Year)		lece (State or Foreign itry)
	Director	238-36-4185	73	Yrs.			August 2	21, 1927	Benso	on, NC
	9	Usuet Residence of Decedent								
	M Page	10e. State 10b. County		ty, Town or Location					1	Od. fnside City Limits
	Me The st	Maryland Prince G	eorge's Fo	restville						1 ☐ Yes 2 No
	with the Marylan a or 28a-f show be notified at Director	10e. Street and Number		10f. i	Zip Code			10g. Citizen of W	hat Cour	itry?
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	r Here 23 iner must Funeral	dd Admirol Chause	12. Was Decedent Ever in U	IS 13 Was De	cedent of H	ispenic Origin? (5	Specify Ves or No	- 14. Raca	- Amaric	an Indien,
	ler des lems iner.m	11. Marital Status	Armed Forces?	If Yes, s	pecify Cubs	an, Mexican, Puar	to Rican, etc.)		k, White,	
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	10	30. Neme end eddress of person who o	completed cause of death (Itar	m 23a) (Type, Print)	-	1 01	11.1	C = 14	/ ~	-7-1
	P	30. Name and address of person who con George C - Ha	War, Jr. M	.O. 4850	) tor	bes plu	u Lann	um, ma	· u	106
	State	31. Dete filed (Month, Day, Year)	., ., 32. Registrer's Signa			,				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Month Year Physician DECEMBER 1912000 cation of Death 4c. County of Death INEZ 2350 I. PENNOYER /Medical 4e Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death Examiner LANHAM PRINCE GEORGES DOCTORS HOSPITAL If Under 1 Yaar If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (fn yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) **Funeral** Deys Months 1 M 2 F Hours Yrs. Director 266-32-6182 FLORIDA Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show solds! Examiner must be notified at 1 Nas 2 No Director MD. ANNE ARUNDEL CROFTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? EASTHAM CT. #21 925 21114 U.S.A. death Funeral 12. Wes Decedent Evar in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritel Stetus Bleck, White, etc. 72 hours after 1 Yes 2 No No If Yes, Give Yaer or Detes: 1 Nevar Married 2 M Merried 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WELLIND d be filed within 72 hor antal Hygiena. ced other than "nature c avant, the Manice! Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 HOMEMAKER HOME 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) s 1 and 2 should be fill I Health and Mental H tam 27 Is marked oth other traumatic avan Be SAMUEL S. IVEY IDA FRANCIS **ADAMS** 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Health tem 27 RAYMOND PENNOYER/HUSBAND #10 Itam 2. SAME AS ITEM Baltimore, 20b. Plece of Disposition (Nama of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Pages 1 permit. Pages Department of Important: If it any injury or o 1 ☐ Buriel 2 【Cremetion 3 ☐ Ramoval from Stafe 4 □ Donetion 5 □ Other (Specify) 12/21/00 RIVERDALE, MD. CHAMBERS CREMATORY 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility 5801 CLEVELAND AVE. MO0091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medical F, aande M Examiner Physician/Medicai Examiner attending physician and for use as the bunal-transit certificata be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or each consequence of): amenic Due to (or es a consecu rasulting in death) Lest by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 23b. Did tobacco use contribute to the cause of death? 5 1 Yes 200 3 Probably 4 Unknown been signed by should be deta by Completed 24b. Were autopsy findings 24e. Was en eutopsy available prior to completion of ceuse of death? performed? certificate has page 200 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes cese referred to medicel 26. Place of Deeth (Check only one) Hospitel: 1 panient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No this To the Hospital or Attending Phwithin 24 hours after deeth.

To the Funeral Director: After it completely filled in by the funera 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 Deleturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the fime, dete end plece, and due to the cause(s) end manner es steled.

Discretifying Physician: To the basis of axaminetion and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) 29a. Certifier edicai (Check only one) 29b. Signature and title of ceptifier 29c. License number 29d. Dete signed (Mopth, Day, Year) 30. Nerge end eddress of person who completed cause of deeth (Itam 23a) (Type, Print) 9135 SEL PISCATRONA 0 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture DEC 22 2000 Separas

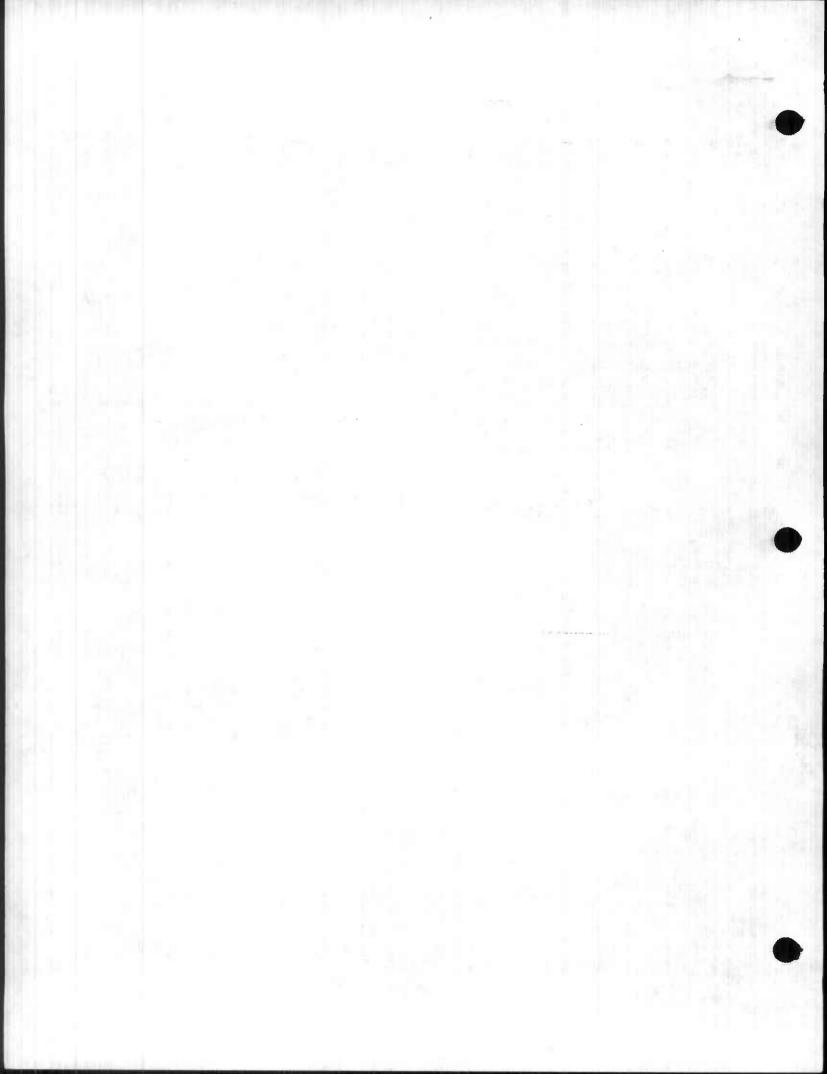
DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Lines 23b. & 23c./WCHD/12-15-00/SC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** George Constantinous PAPPAS 31.10 28 Nevember 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys Months 1⊠M 2□ F Yrs. 85 212-14-7135 Dec. 20, 1914 Pennsylvania Director Usual Residence of Decedent 10a Stefe 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 1 ☐ Yes 2 No Maryland Directo Washington Hagerstown must be notifie 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code Name 23a or 10828 Rosewood Drive 21740 USA Was Decedent of Hispenic Origin? (Spacify Yes or No-If Yes, spacify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. the Medical Exerniner 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: white ģ 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) then Elementery/Secondary (0-12) College (1-4or 5+) maintenance aircraft 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) 2 should be fi h and Mental H is marked off Constantinous Pappas Angeliki unknown 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informent's Neme/Reletionship (Type, Print) Pages 1 and 2 r 10828 Rosewood Dr., Hagerstown, Md. 21740 of Health Item 27 Angela Rutherford - daughter Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetery or other plece) 20c. Location - City or Town, State 20e. Method of Disposition important: If its any injury 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Rose Hill Cemetery 12-1-00 Hagerstown, Maryland 22. Name end Address of Facility 21. Signeture of Funeral Service Licensee MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 Approximate Intervel Between Onset end Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical monary Examiner Due to (or es consequence of): Examiner MANUAL AND Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury fine Initiated events resulting in deeth) Lest Due to (or es e consequence of) Dehydration Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 2 thiknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed certificate has 1 Yes 2 No 1 Yes 2 No rootate Carcer 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospitel: 12 Inpatient 2 ER/Dutpetient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1□ Yes 2☑ No Certification: To to 報 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Division After 1. Naturel Injury 5 Pending 1 Yes 2 No investigetion 2 Accident by the 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) or A nitter 4 Homicide To the Hospital within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner as steled.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner steled. 29e. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 2-2-00 30. Name and address of person who completed cause of death (Item 23a) (Typa, Print) 350 21740 31. Dete filed (Month, Day, Year) 32. Registrer's Signature

DHMH 16 Rev 6/95

Registra

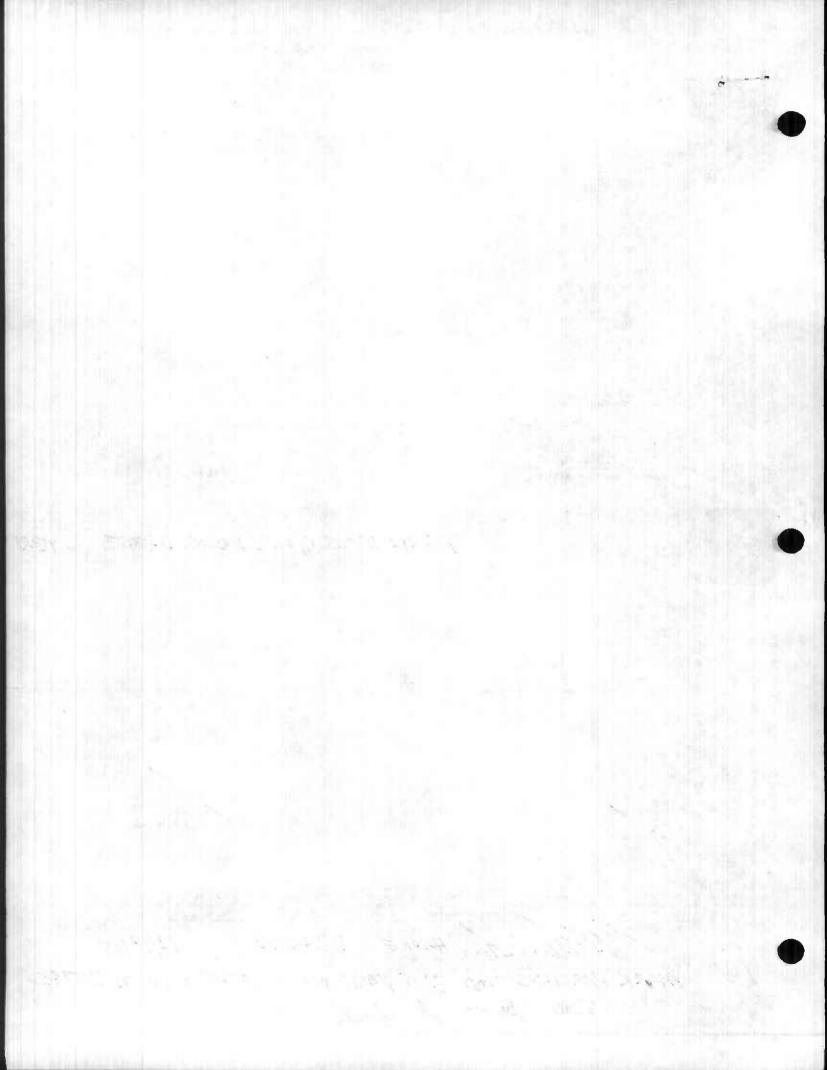


Amend# 17	.P	Per FH PGC 12-19-2	000 cr		Cei	tificate	of Death		Reg. No.	-3 (	U U U
Physician		1. Decedent's Neme (First, Middle, La.						2. Date of De Month	Dev	Year	3. Time of Death
/Medica	1 -	Garnett W.	Robin					Decemb		2000	8:30 AM
Examine		4a Facility Neme (If not institution, given 9218 Crandall Rd		7)			4b. City, Town, or Lanham	Location of Death			orge's
Funeral Director		5. Social Security Number 6. S 579-09-0184	ex 7. Å	nga (In yrs. 85	last birthday) Yrs.	If Under 1 Y Months D	aar If Under 24 Hr eys Hours Mir	8. Dete of Bird (Month, Da March			lace (State or Foreign try) nington, D
yland M # # M	- 1-	Usuel Residence of Decedent  10a. Stata 10b. County		10c. Cit	ty, Town or Lo	cation					Od. Inside City Limits
Mar and Mar	oto	MD Prince	George's	Lan	ham						1∏Yes 2□ No
or 28s-4	Directo	10e. Street and Number				10f. Zip Co			10g. Citizen of V	What Coun	try?
aft w	1	9218 Crandall Rd				20706			U.S.A.		
Maryland 21215-0036 to should be find within 72 hours after de- th and Mental Hygiene. T? Is marked other then "natures", or terms t traumetic event, the Medical Exercitive in	by rune	11. Meritel Status  1 □ Nevar Married 2 □ Married  3 □ Wildowed 4 □ Divorced	12. Wes Decedan Armed Forcas 1 Tyas 2 If Yes, Give Year or Detas	? } No		Was Decedent If Yas, specify 1 ☐ Yas 2 ☐	of Hispanlc Origin? ( Cuben, Mexican, Pue No Specify:	Specify Yes or No rto Rican, atc.)	Specify	e - America ck, White, e c: BJ	
O-S ho	Det	15. Decedant's Ed	lucation		16a. Dece	dent's Usuel O	ccupation	adina	16b. Kind of B	usiness/Ind	lustry
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Name of the state	0	12th	1		Eng	ineer			Gover		
Du Subs	e g	17. Father's Name (First, Middle, Last)	/					eme (First, Middle,		-	
yla outd Man Man mile	0	John Randolph			1			Robinson			
Mar 12 sh 12 sh 18 m		19e. Informant's Neme/Reletionship (				- Co-Hillian	treet and Number or F		er, City or Town,	Stete, Zip	Code)
e, Parent	-	Maria Williams/G1 20e. Method of Disposition	anddaugh			Cranda]	l Rd. Lan	ham, MD 2	20706 20c. Location -	City or To	un State
10 m		1 Deuriel 2 Cremetion 3		9	cametery, crer	netory or other	r plece)				
Baltimore, semit. Pages 1 as bepartment of Nea mportant: If them inty Injury or other mice.	-	4 Donetien 5 Other (Specific		I'I		d Veter		12/20/00 J.B.Jenk			
Ball Ball	1	21. Signature of Funeral Service Licer	sae				ddress of Fecility adover Rd.			20785	ione
	1	23a. Part 1. Enter the disease, or com- shock, or heart failure. List only									Approximete
Physician /Medical Examiner		Immediate Cause (Finel disease or condition resulting in death)	Ø		ARKII or es e consec		SM/PAR	KINSON	's DISEA	se.	SYER
secuted al-irensit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	b	Due to (d	or es a consec	quence of):					
S876(cate be physicies the burn	200	cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest	cDue to (or as a consequenca of):								
Box 6 sath certif	2		d								
Boath death of for u		Pert II. Other eignificant conditions o	natributing to death	but not res	sulting in the u	nderiving caus	e civen in Part I	23b. Did	tobacco use co	ntribute to	the cause of death?
ds, P.O. Baires that the death signed by the atterd be detached for	by Physiciany							10	Yee 20 No	3 Prot	bably 4 Unknow
Records,	Completed							24a. Wes	en eutopsy emed?	CO	ere autopsy findings silable prior to mpletion of cause death?
	E							10	Yes 2 No	10	Yes 2 No
of Vital IP Physician: The		25. Was case referred to medical		110	Salle	(a) (b)	26. Place of D	eeth (Check only	one)		
Of Vita	0	exeminer?	Hospitel: 1 Inpa	tient 2	ER/Outpatier	nt 3 DOA	Other: 4 Nursing	Home 5 Resi	dence 6 □Oth	ner (Specify	y)
On of alling Phys After this funerel d		27. Menner of Deeth  12 Neturel 5 Pending	28a. Data of In	jury lev Year)	28b. Tima o Injury	1 28c.	Injury et Work?	28d. Describe	how injury occur	red	
SO S	Sati	2 Accident Investigation		,,,,,,	,.,	М	1 ☐ Yes 2 ☐ No				
Division  at or Attending a star death. It Director: After ed in by the tune	Certific	3 Suicide 6 Could not b 4 Homicide determined	289. Placa of t	njury - At h etc. (Speci	ome, ferm, str	reet, factory, of	ffica	28f. Location ( City or To	Street and Numi wn, State)	ber or Rura	I Route Number,
DIVISION To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Certification.			of examine			he time, dete end ple my opinion, deeth oc				
To the within comp		29b. Signeture ended a discertifier	w. An	H	IDSPICE		cense number 2409	3	29d. Date signe	od (Month,	Day, Year)
(10)		30. Name and address of person who	completed cause of	deeth (Iter	m 23a) (Type,	Print) SAUT	AVE COL	प्रदुर्ख	PARK	mo z	20740

State Registrar DEC 19 2000 Ser

62. Registrer's Signeture

Gode



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

42506

	Physician	1. Decedent's Nama (First, Midd Sarah Ell		son						2. Data of De Month Decemi	_	2000	3. Time of Death 11:19 P.1
	/Medical Examiner	4a Facility Nama (If not Institution	_				4	b. City, Too Chev	_	ocation of Deal		ty of Death	rae's
	Funeral Director	Prince George 5. Social Security Number 577-20-7274	6. Sex	7. Age (In yrs.		If Under 1 Months I	Yaar Days	If Under:		8. Data of Bi (Month, D			place (State or Foreign
Marviand	f show led at	Usual Residence of Decedent  10a. Stata  D.C.  10b. Count	N/A	10c. Ci	ty, Town or Lo	cation	W	ashin	gtor				0d. Inside City Limits XXYas 2□ No
hwith the Mand	4 10	10e. Street and Number 1805 18th St	.,S.E.			10f. Zip C	oda	2002	0		10g. Citizen of U.S.	What Coun	itry?
020	ar, or terms 23a Examiner must by Funeral	11. Marital Status  1 Nevar Married 2 Mar  3 X Widowed 4 Divorce	rried 1 Yas	s 2XXXIIIo Giva		Was Deceder If Yas, specify		spanic Orig n, Mexican Specify:	gin? (Sp , Puarto	ecify Yas or No Rican, atc.)	14. Ra Bla Speci	ce - Amaric ack, Whita, fy: Bla	
Maryland 21215-0020	yglene. ser than "naturn rt, the Medical Completed	15. Decade (Specify only high Elementary/Secondary (0-12) 9th	nt's Education ast grada completed College	d) (1-4or 5+)		dent's Usuat ( kind of work DO NOT use todial				ing	16b. Kind of E		
/land	Aental Hyg rked other tic event, To Be C	17. Fathar's Nama (First, Middla Benjamin Rob:								a (First, Middle llis	, Maiden Suma	ma)	
. 5	ath and i	19a. Informant's Name/Relation Clarence C. Rol		n	19b. Mailii 5001	ng Address (S Hagan	Rd.	nd Numbe	r or Rur ple	Hills,	Md. 20	748. Zip	Code)
altimore	nent of He ant: if Bern ary or oth	20a. Mathod of Disposition  1 Durial 2 Cramation  4 Donation 5 Other (5		m State	Place of Disponentary, crementary, crement	natory or other	of er place	e) 12	2/23	Data /00	20c. Location Washin	-	
Balt	Depart Import any Inj ans.	21. Signature of Funaral Services	Licensee  W.	Brat				_			Co.,Inc. Wash.,D	.c. 2	0019
4	nysician Medical	23a. Part 1. Entar tha disease, o shock, or heart failura. Lis	t only one cause on	aach lina.	th. Do not ent	ar tha moda o	of dying	g, such as	cardiac	or respiratory a	arrast,		Approximata Intarval Batween Onset and Death
	xaminer	Immediata Causa (Final diseasa or condition resulting in death)	a. A1	Dua to (	or as a consec		Ca	NDIO	VAL	CULA	n Dis-e	QSQ.	yeaw
O,	hysician and the buriei-transit dicai Examir	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury	b	Dua to (	or as a consec	uence of):				7		1	
X 68760	attending physician and for use as the buriel-transit stary.	that initiated evants resulting in death) Last	c	Dua to (d	or as a conseq	uance of):							
ords, P.O. Box	9 2 3	Part II. Other eignificant conditi	4711011	715				en in Part I.			tobacco use co		the cause of death?
E O	2 should	Conge	stive	Heart	Fa	ilor-	e			24a. Was	s an autopsy omed?	av	ara autopsy findings allable prior to mpletion of cause death?
tai R	s cartificate hadirector, page	25. Was casa referred to medical						00 01	-151		Yas 2 No	10	☐Yas 2☐No
of Vitai	l director	axaminar?	Hospital:	Inpatient 2	ER/Outpatier	t 3 DOA	Othe	. ·		h (Check only	ona) idence 6 □Ot	ther /Snecil	(v)
Vision of	After th funeral	27. Manner of Death 1 Natural 5 Pendi 2 Accident invast	28a. Dat (Mo	e of Injury onth, Day Year)	28b. Tima of Injury		Injury Work				how injury occu		,
IVIS X Atte	free deet freector: n by the rtifical	3 ☐ Suicida 6 ☐ Coutd 4 ☐ Homicida detam	nined 288. Plac	ce of Injury - At h	oma, farm, str	eet, factory, o	ffice				(Street and Num wn, Stata)	ber or Rura	al Routa Number,

To the Hospital or Attawithin 24 hours after dea To the Funeral Director completely filled in by the

State Registrar

Medical Certifi

4205 Queensburged Hyattsville MD 20781

ted cause of death (Item 23a) (Type, Print)

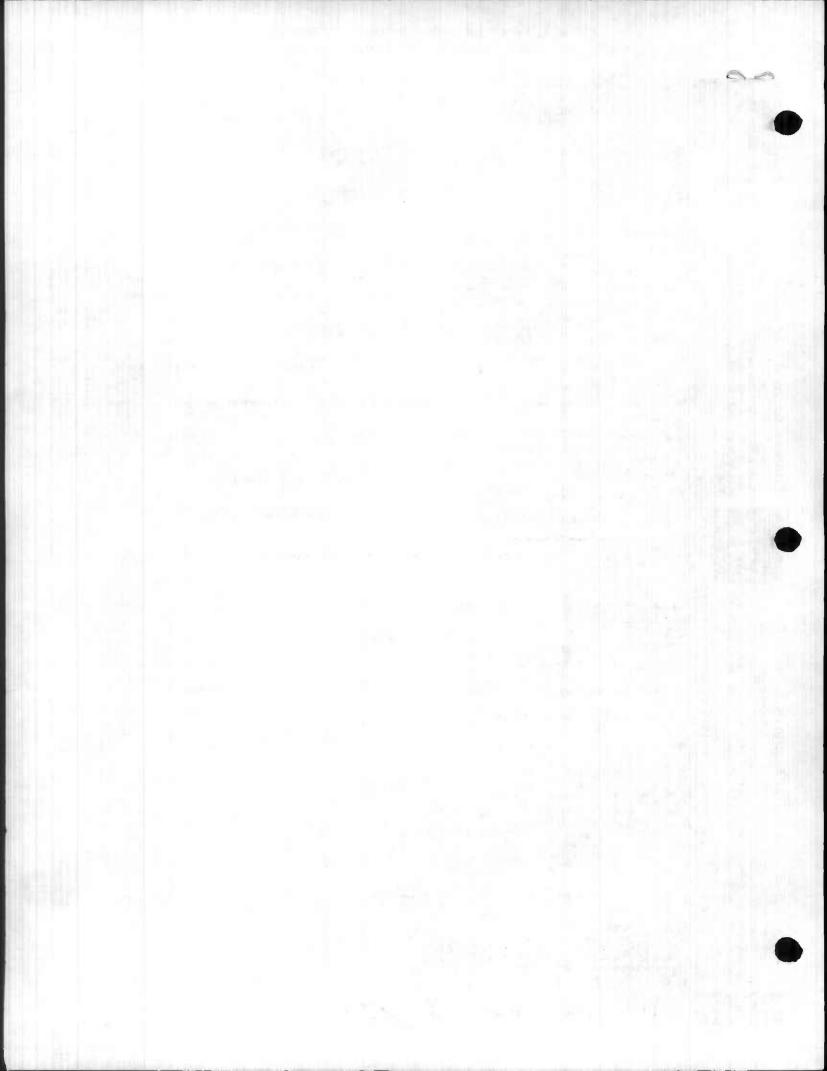
**DHMH 16 Rev 6/95** 

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. Licensa number

D01852

29d. Data signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Deeth Yee Reynolds Florence 15, 2000 23:50 December 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth Southern Maryland Hospital Clinton Prince George's If Under 1 Yeer Hours Min. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Months Deys 579-22-5387 March 18, 1924 Washington DC 76 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 √Yes 2 No Forestville Maryland Prince George's 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 20747 1646 Addison Road South USA 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerlo Rican, etc.) Rece - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Merital Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Cook Government 12th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Henry Reynolds Virginia Williams 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Bonnie Reynolds/Daughter 1646 Addison Road South, Forestville, MD 20747 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete tXDBuriel 2 ☐ Cremetion 3 ☐ Removel from Stete 12/21/00 Clinton, Maryland Resurrection Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards Funeral Home 3910 Silver Hill Road, Suitland, MD 20746 Approximete Intervel Between Onset end Death 23e/Fert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in deeth) UNKNOWN unllnows Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest Due to (or es e consequença of): NSulin Dependent DIABETES cen Known Due to (or es e consequênce of) 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | binknown DEMENTIA 24a. Wes en eutopsy performed?

Physician /Medical Examiner

permit. Peges 1 and 2 should be flik Department of Heelth end Mental Hy Important: If item 27 is marked other any Injury or other traumatic event, DAGS.

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

Be

**Funeral** 

Director

ed other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at

filed within 7 Hyglane. marked other than

the Manyland

Saltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

or Attending Physician:

Physician/Medical Examiner The lew requires that the death cartificate be executed stranding physician and for use as the buriel-transit

by

Completed

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Certification:

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Director: Aft
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To the Hospital within 24 hours a To the Funeral C complately filled

filled in by

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

BMOTOMA RIGHT BREAST

20 No

1 Yes

24b. Were eutopsy findings eveilable prior to completion of cause of deeth?

1 ☐ Yes 2 ☐ No

25. Wes cese referred to medical Hospitel: 14 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2₽No 1 Naturel

5 Pending investigation 6 Could not be 28e. Date of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury at Work? 2 No

Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 28d. Describe how injury occurred

26. Plece of Deeth (Check only one)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier

2 Accident

3 Suicide

4 Homicide

Medical Examiner: On the bast of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end menner steted.

29b. Signature and title of cartifies

29c. License number

29d. Date signed (Month, Dey, Year)

DECEMBER, 16,2000

Hrastoo

o completed ceuse of deeth (Item 23a) (Type, Print) Surratts Road, Clinton MD 20735 azdani, M.D. 7563

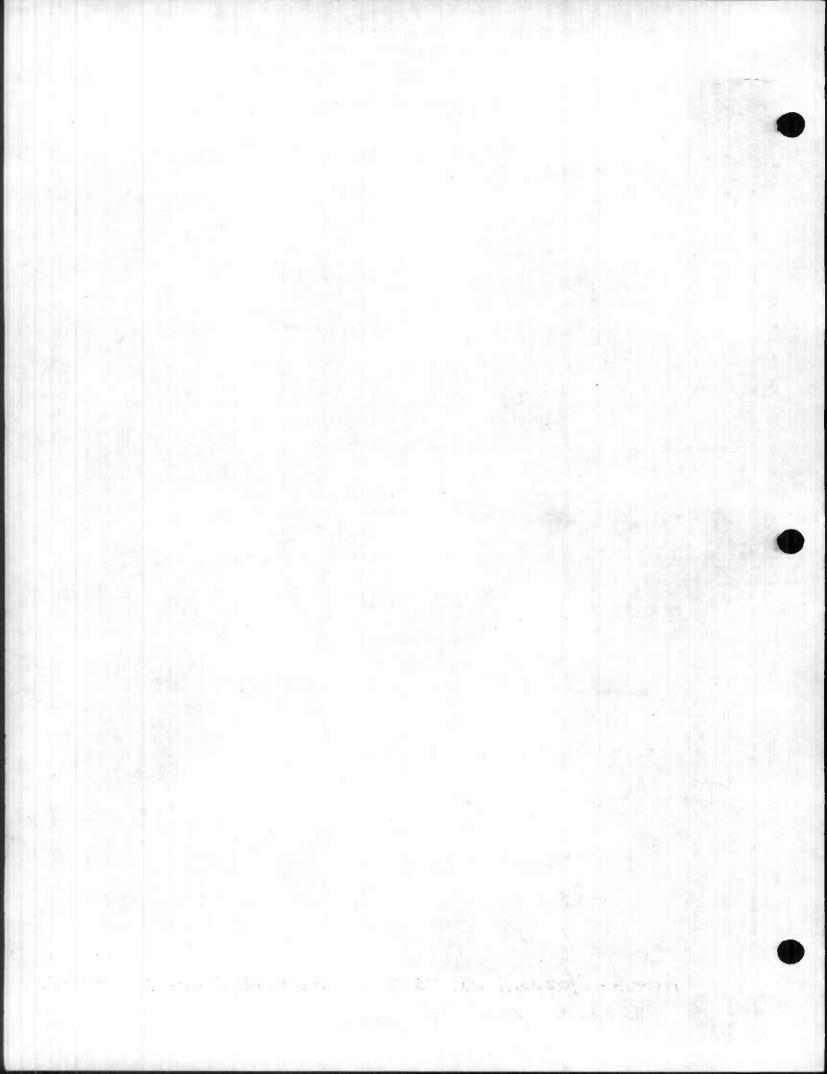
Registrar

31. Dete filed (Month, Day, Year)
DEC 2 0 2000

32. Registrer's Signetur

**DHMH 16 Rev 6/95** 

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year 11:56 AM Susie M. Royster Peca les 17 2000 4b. City, Town, or Location of Death If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4c. County of Death 4a Facility Name (If not institution, giva street and number) Prince George's Hospita 6-corges rivue Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 577-28-5972 1 M 2 XF 76 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Charles co 1 ☐ Yes 2 X No MD Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 10174 Decker Court 20630 USA 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Yes 2 No Yes, Give 1 Yes 2 No Specify: Specify: black 3 ₩ Widowed 4 Divorcad Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) George Washington Elementary/Secondary (0-12) College (1-4or 5+) Dietician Hospital 12th 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Meiden Sumeme) Ben Lewis Gracie Ward 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10174 Decker Court Waldorf, MD 20630 Larry Royster/son 20b. Place of Disposition (Nama of cemetery, cremetory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Crematory 12-22-00 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Spacify) 22. Name and Address of Facility Maral Servica Licenses B.K. Henry Funeral Chapel Inc. Mo178 420 H Street NE Washington the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 420 H Street NE Washington DC 20002 tha disease, or complications that can heart failure. List only one cause on each Arterioschertic Cardidovas una Diseas Immediate Cause (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequance of) 23b. Did tobacco usa contributa to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examinary 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Othar (Specify) 2DER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending

physician end the buriel-transit death certificate be executed Box 68760 98 use for ed by the e signed t Division of Vital Records, certificate has b lirector, page 2 s this funeral After

Examiner Physician/Medical þ Completed Be 2 Certification:

**Physician** 

/Medical

Examiner

**Euneral** 

Director

ns 23a or 28a-f show

Director

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permit. Pages 1 and 2 should be filled within 72 hours effer deal Department of Health and Mentel Hygiene. Important: If flem 27 is marked other than "natural", or flems any injury or other traumetic event, the Mudical Examiner manages.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

or Attanding efter death. Director: Af P Hospital 24 hours To the Hosp within 24 hor To the Fune completely fi

edical

State Registrar

29c. Licanse number

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Hedical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29d, Date signed (Month, Dev. Year)

2000

28f. Location (Straet end Number or Rurel Routa Number, City or Town, Stete)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Cheverly, Many And 3001 Sylvester Hospital Drive

6 ☐ Could not be

2 Accident

3 Suicida

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of cartifier

2. Registrar's Signature

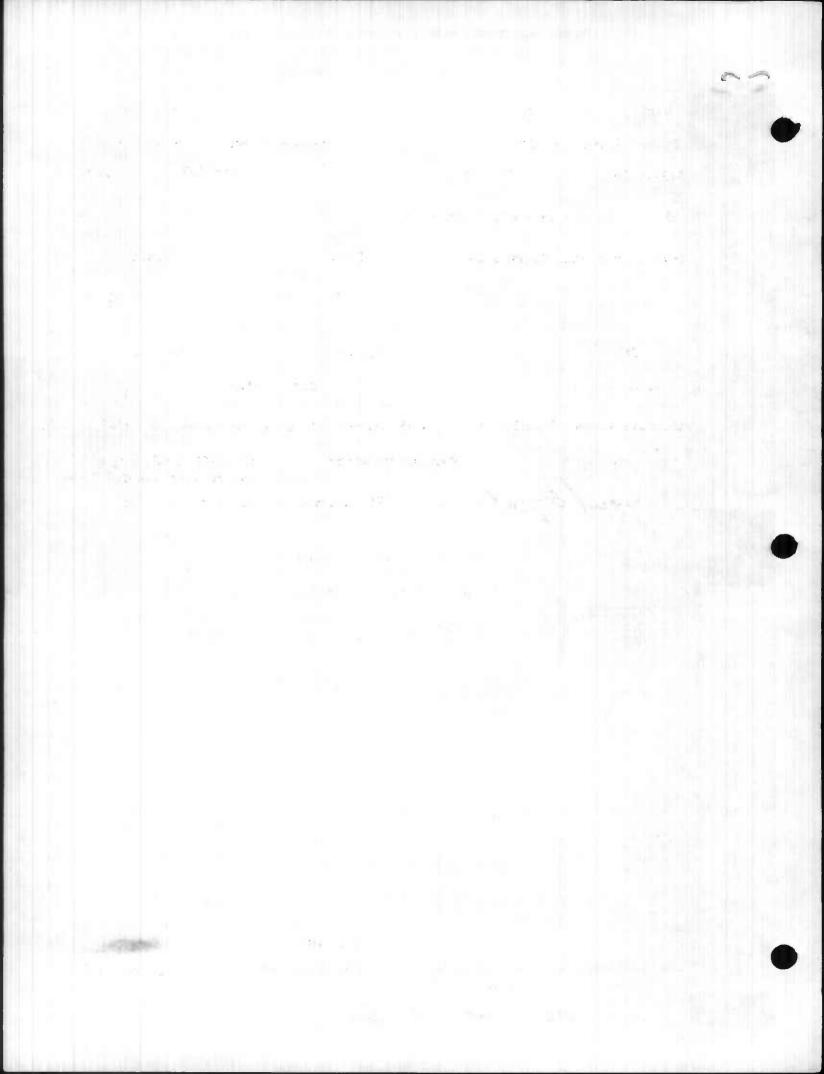
00

Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

# MAM ZOMAINE

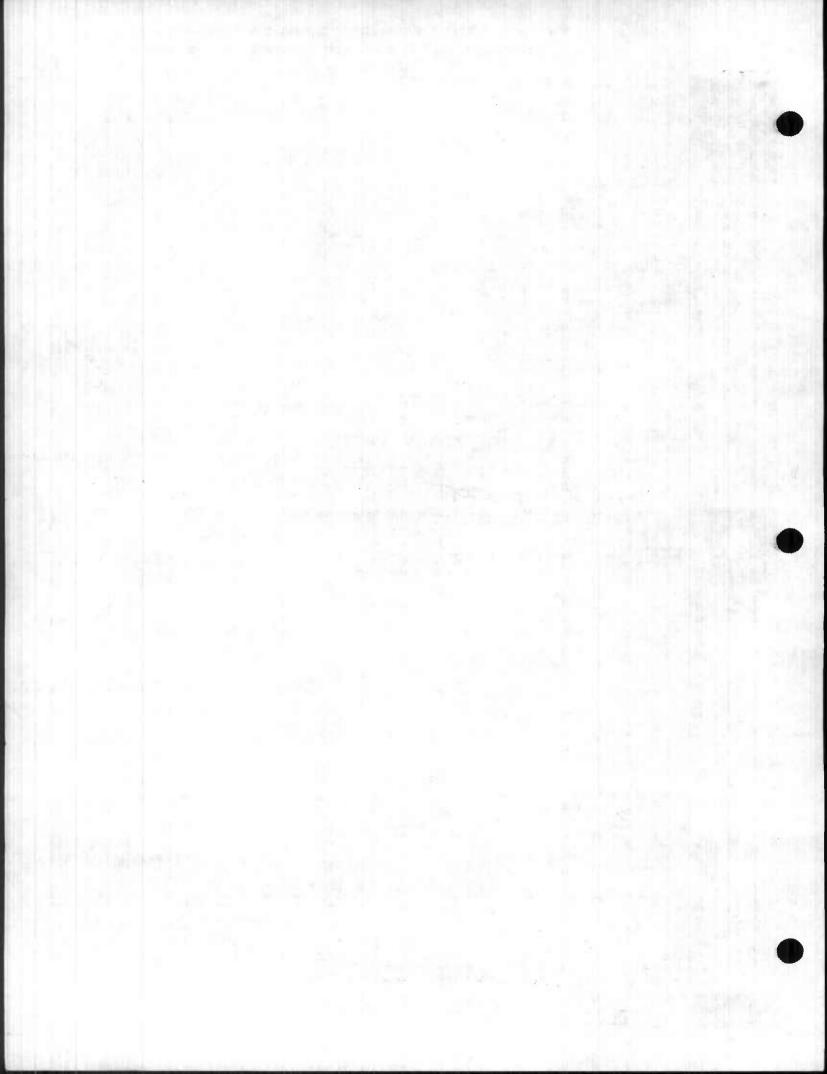
			State of Mai		ertificate		nd Mental Hy	giene	1,2	2509		
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	Physician /Medical Examiner	Mary D 4a Fecility Neme (If not institution, g	Romain ive street and number)			4b. City, Town	, or Location of Deel	11 2	000	4:30 pm		
F	uneral	Prince George Ho 5. Social Security Number 6. 579-76-2609		(In yrs. last birthda) Yrs.	/) If Under 1 Y Months Da		y MD Hrs. 8. Date of Bi Min. 9-1-19	Prince	Georg 9. Birthplace Country) Maryla	te's e (State or Foreign		
pu		Usuel Residence of Decedent		10. Oh. Taua sal					101	In all to O'the Limite		
arylar	28a-f shown and and and and and and and and and an	MD Prince (		10c. City, Town or I Suitland						Inside City Limits  1 Yes 2 No		
the M	or 28a-f s be nourised	10e. Street end Number	scorge s	Darciana	10f. Zip Cod	de .		10g. Citizen of V		**		
death with the Maryland	23a or	5078 Silver Hill	Court #104		20746	5		U.S.A	١.			
- 6	al, or flame 23a or 28e-f sho Examiner must be nutfled at by Funeral Director	11. Marital Status  1 □ Never Merried 2 □ Married  3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 24 No If Yes, Give Yeer or Detes:		. Wes Decedent If Yes, specify 0 1 ☐ Yes 2 🛣		n? (Specify Yes or Ne Puerto Rican, etc.)	Blac	e - American k, White, etc. Black			
21215-0020 d within 72 hours af	natur soical leted	15. Decedent's (Specify only highest g	rade completed)	(Giv	edent's Usuei Or re kind of work de DO NOT use re	one during most o	f working	16b. Kind of Bu	siness/Indus	try		
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Aar 2 sh		19e. Informent's Name/Relationship					or Rural Route Numb			ide)		
Baltimore, N		Michelle Thomas ( 20a. Method of Disposition 1⊠ Buriel 2 □ Cremetion 3		20b. Placa of Dis	Silver position (Name of ematory or other	of	rt Suitla	Suitland, MD 20746  Dete 20c. Location - City or Town, Stete				
tim Pag	Table 1	4 Donetion 5 Other (Spec	sity)	Harmony			12-18-00					
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	2.0.0	20a Part Finter the disease, or co	trate		474 Lan	dover Rd	Landover	MD 207		pproximate		
/M Example of the control of the con	ian and right leading in a light	Immediate Ceuse (Final disease or condition resulting in death)  Sequentielly list conditions, if eny, leeding to immediate cause. Final Indexion	e. <u>НУРЕ</u> D b. <u>Е</u> NÒ	POSMOL ue to (or es e cons	equenca of):  RE equenca of):	OmA	isense	Man and a series of the series		nset end Deeth		
Box 68760 death certificate be e	been signed by the attending physician and should be datached for use as the buriat-transit leted by Physician/Medical Examir	Ceuse (Disease or injury that initiated events resulting in death) Lest		ue to (or es e conse			MX	40				
	the att ned fo	Pert II. Other eignificent conditions	contributing to death but	not resulting in the	underlying caus	e given in Part I.	23b. Did	tobecco use co	ntribute to th	ne cause of death?		
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ecords, P.O	8 0 0						24e. Wa	s en eutopsy ormed?	eveila	eutopsy findings able prior to eletion of cause eth?		
Tha Tha	ractor, page 2			10	Yes 2 Dino	1 □ Y	es 2□ No					
/ita	actor, Be	25. Was case referred to medical examiner?	Hearital				f Deeth (Check only	one)				
of Vita	this aid	1 ☐ Yes 2 Ø No 27. Manner of Death	Hospital:				ing Home 5 ☐ Res	how Injury occur				
Division of Vital Records, to Attending Physician: The law requires ti affer death.	To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	1 ZNaturel 5 Pending 2 Accident investigati 3 Suicide 6 Could not determine	be on Dian of lains	v - At home, farm,	М	Injury et Work? 1   Yes 2   No	28f. Location	(Street and Numb wn, State)		loute Number,		
To the Hospital	the Funeral empletely filled Medical C		Phyelcien: To the best of aminer: On the basis of e	xaminetion and/or								
To the	To the	29b. Signature end title of certifier	) he	5u.		cense number		29d. Dete signed		y, Year) 2000		
	4)	30. Name end eddress of person wh			e, Print) 300]		al Dr. Che					
	State Registrar	31. Dete filed (Month, Day, Year) DEC 2 2 200	32 Registrer		Soon		- 6100.	11.9		12		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



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			Ce	ertificat	e of I	Death		F	leg. No.	-7	6010	
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Physician /Medical		MANELLO					D	ECEMB:	ER 19, 2	000	9:00A	
Examiner	4a Facility Nama (If not institution, giv Laurel Regional				4	Laur		ion of Death	4c. County o		orge's	
Funeral Director	5. Social Sacurity Number 6. S 204–22–5583	Sex 7. Age (In In I	yrs. last birthday 76 Yrs.	Months	Days	If Under a	24 Hrs. 8. Min. D	Date of Birth (Month, Day )ec.8,	1924 F	9. Birthpl Count enns	ace (State or For In) ylvania	
Pu s	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or I	ocation						10	Od. Inside City Lin	
or 28±f show be notified at	Maryland Prince		Beltsvi								1 ☐ Yes 2 ☐	
	10e. Street and Number 4213 Brandon Lan	e			Code 20705	5			United		,	
ors after or to the by Full	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yas, Give Yaar or Dates:	in U,S. 13	. Was Dece If Yes, spe 1 \( \text{Yes} \)	cify Cuba	ispanic Origin, Mexicen Specify:	gin? (Specify , Puarto Rica	/ Yes or No- an, etc.)		- America , Whita, a		
ygiene.  The Medical E.  Completed by	15. Decedent's E. (Specify only highest gra		16a. Dec	edent's Usu re kind of wo DO NOT u	al Occup	ation du <i>n</i> in <i>g m</i> ost	of working		16b. Kind of Bus	siness/Ind	lustry	
r than tre Man	Elementery/Secondary (0-12)	College (1-4or 5+)		maker	se retired	,			OWN	home		
tal Hygie d other event, u	17. Fathar's Name (First, Middle, Last		TIOMIC	manca.		18. Motha	r's Nama (F	irst, Middla,	Maiden Sumama			
marked of marked	Alberico	Cicio	ni			Mari	ia		G	reco		
pue Band	19a. Informant's Name/Relationship (Victor A. Romane			iling Address		a <i>nd N</i> um <i>be</i>	or or Rural R	oute Numbe	r, City or Town, S	State, Zip	Code)	
reges 1 end nent of Heelth mt: If Item 27 iry or other tr	20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specif	Removal from State	Db. Place of Disposer cometary, cr	ematory or	other plea			bate	20c. Location - 0			
Department of Important: If I any Injury or once.	21. Signature of Funeral Service Licer			22. Name at	nd Addres	s of Facility	y vardt.	Funera	al Home,	P.A	•	
	23a. Part1. Entar the disease, or com	plications that caused the								-	Approximate	
incere be executed by physician and its the bunial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate	b	to (or as a conse				4			1		
	Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Cause (Diseasa or injury that initiated events resulting in death) Last	c. Due	to (or as a conse	equence of):						† †	7	
e ettending od for use as ician/Me		U.								1		
by the	Part II. Other eignificant conditions of	ontributing to death but no	t resulting in the	underlying (	cause giv	en in Pert I.		23b. Did t	obacco use con o 2000		the ceuse of density 4 Uni	
s been sign 2 should be pieted by			24a. Was an autopsy performad? 24b. Were autopsy fir availabla prior to completion of ce of death?			ailabla prior to appletion of caus						
page Com									es 2 Divo	1□	Yes 2□ No	
s certificate director, pag	25. Was cese refarred to medicel examiner?				1011		of Death (C	heck only o	ne)			
8 D									Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred			
within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral Medical Certification:									28f. Location (Street end Number or Rurel Route Numb City or Town, State)			
n 24 hours	29e. Certifier  (Check only one)  29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and menn one)											
Vithin Comple	29b. Signature and the of certifier	1		29	c. Licens	e number			29d. Date signed	(Month, I	Day, Year)	
7	I the Man	V-			02	543	0	79.4	Decembe:	r 19	, 2000	
	30. Name and addrass of person who John Margolis, M	complated cause of death D. 13952 Ba	(Item 23a) (Type	e, Print) Avenu	ae La	urel,	Mary.	land 2	20707			
State	31. Date filed (Month, Day, Year)	32. Begistrar's S	ignature /	-	als							



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ADMEND ITEM: #24A PER VERBAL RESPONSE G793 Rea. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 2000 ROMIE QUINN ROBINSON II 1:32 AM /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico 221 Middle Blvd. Salisbury If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foraign Country) Deys 110 M 20 F 212-76-5607 39 2/16/1961 MDUsual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 221 Middle Blvd. 21801 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 Yes, 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stetus Bleck, White, etc. 1 1 Navar Marriad 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Psychiatric Elementary/Secondery (0-12) College (1-4or 5+) Rehabilitation Agency Social Worker 18. Mothar's Neme (First, Middle, Maiden Sumama) 17. Father's Neme (First, Middla, Last) Romie Quinn Robinson, Sr. Nancy Rebecca Foxwell 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Meagher 221 Middle Blvd. Salisbury, MD 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 Burial 2 Crametion 3 Ramoval from State Old Trinity Church Cem. 12/20/00 Church Creek, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name end Address of Facility Burbage Funeral Home 108 William St. Berlin, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear feilure. List only one cardiac on each lina. **Approximate** Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or es e consequence of): Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medicai Due to (or es e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco µsg contributs to the causs of death? 3 Probably 4 Unknown 1 ☐ Yss No

**Physician** /Medical Examiner

Separtment of Health Important: If Nem 27

b

Pages Impert of

**Funeral** 

Director

28a-f shor

Harna 23a or

ions. I than 'natural', or iten the Medical Examiner.

72 hours after

filed within

should be Mental marked

Maryland 21215-0020

Baltimore,

must be notifi

å signed by Be Completed by certificate has P 874 Medical Certification: Attor Director: J or A To the Hospital within 24 hours To the Funeral C

of Vital Records.

Division

Hospital

24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case refarred to medical 26. Place of Deeth (Check only one) 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury et Work? Neturel 5 Pending investigation 2 Accident 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) end menner statad. 29a Certifier

29c. License number

State

Registrar

00 31. Dete filed (Month, Day, Year) DEC 18 2000

30. Neme and address

29b. Signeture end title of certifier

Registrer's Signetura 32

cause of death

Pullo bull

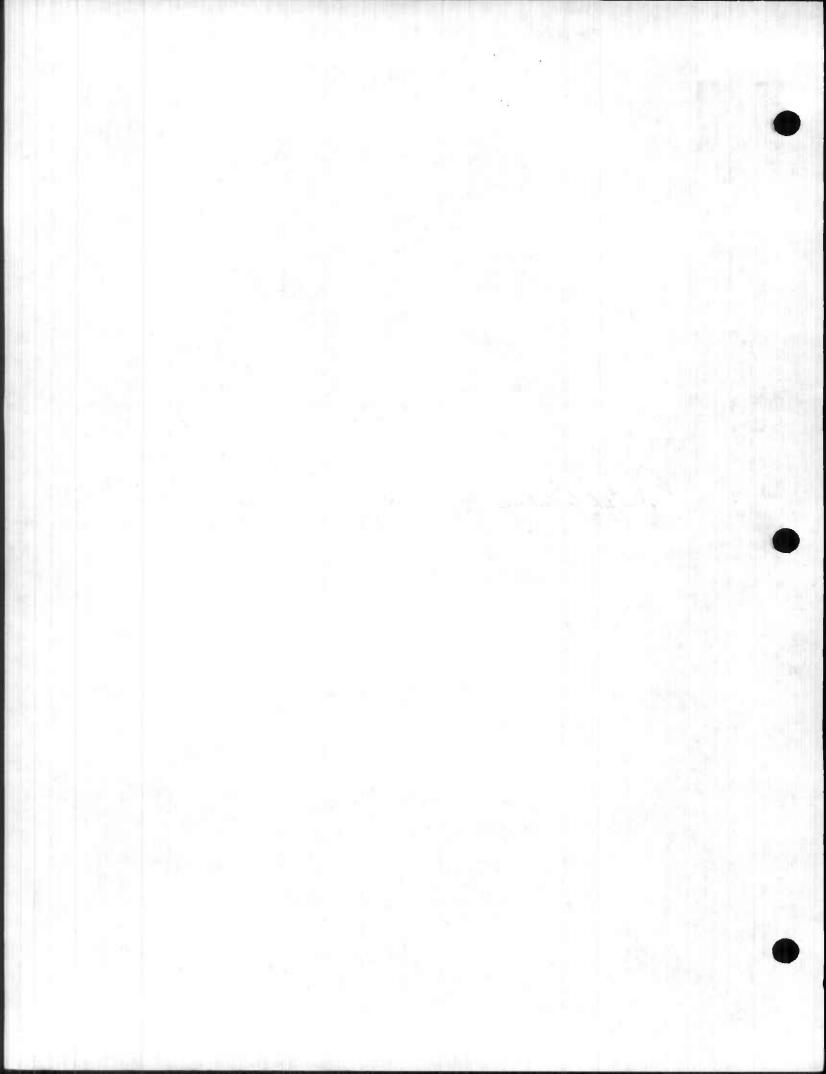
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Walsh,

MB

29d. Data signed (Month, Day, Year)

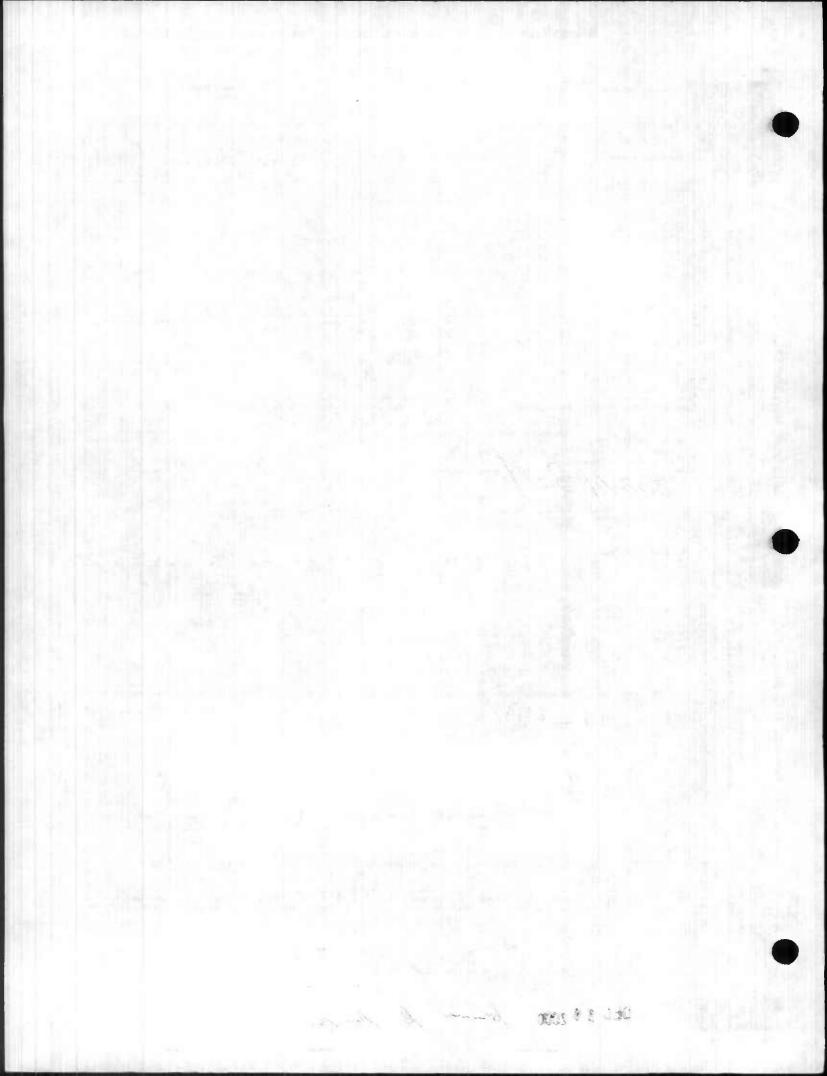
(Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 425 12

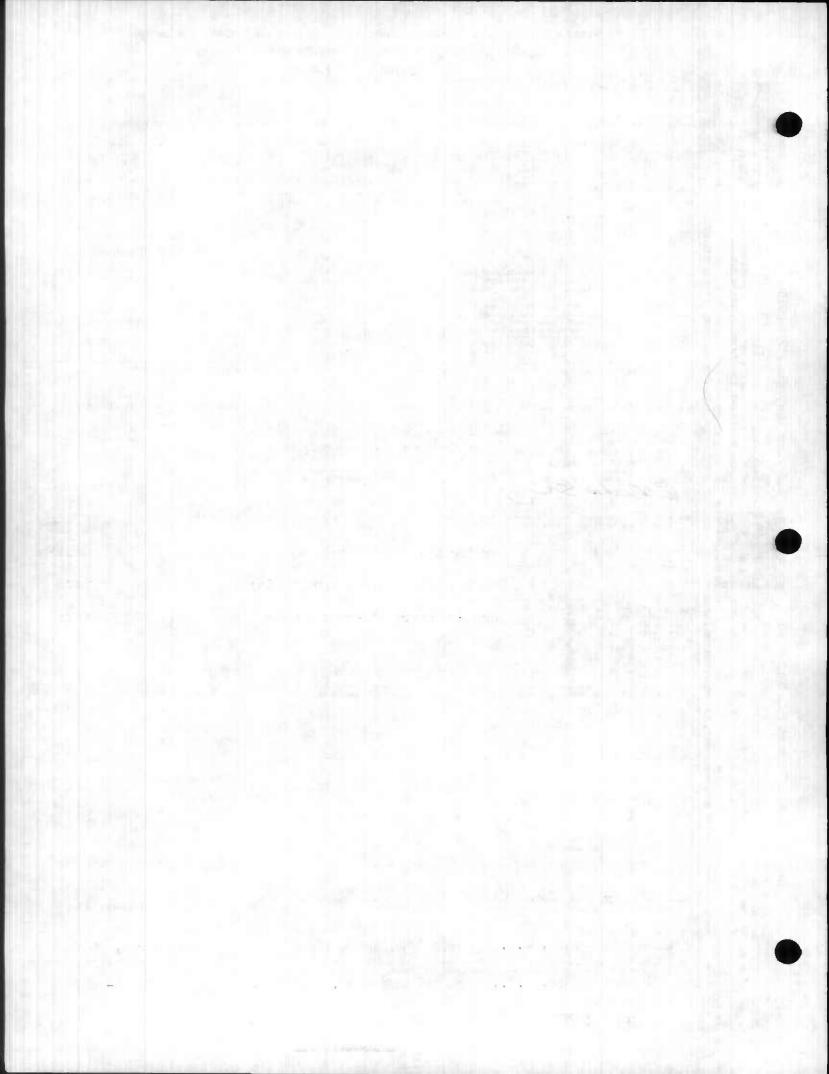
			(	Certificat	e of D	eath	Re	g. No.			
	1. Decedent's Name (First, Middle,	Last)		-			2. Dete of Deat Month	Day	Year 3.	Time of Death	
Physician /Medical	Emil H	ubert	Schulz				December	18, 20	000 2:	15 AM	
Examiner	4e Facility Name (If not institution, g						or Location of Death	4c. County			
	Bayside Nursin	g Center			1	eat Mi			. Mary'		
Funeral Director	174-14-8582	Sex 7. Age 12 H 8	(In yrs. last birtho	Months		Hours A	Hrs. 8. Date of Birth (Month, Dey, June 29,		9. Birthplace Country) Pennsyl	(Stete or Foreign	
. 5	Usual Residence of Decedent  10a. State t 0b. County		10c. City, Town o	or Location		117.00			10d I	Inside City Limits	
or 28e-f short be notified at Director		Mary's		ton Pa	rk					1 ☐ Yes 2X No	
in with the Ma 23s or 28s-f s at be notified al Director	10e. Street and Number 23024 Town Creek	k Drive		10f. Zij	2065	53	1	0g. Citizen of V US			
at, or thems Examinar in  by Funer	11. Marital Status  1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 [XYes 2 ] No If Yes, Give Year or Dates:			dent of His cify Cuban, 2 1 No		7 (Specify Yes or No- uerto Rican, etc.)		e - American li ck, White, etc.		
ed within 72 no yglene. we than "natur f. the Medical Completed	15. Decedent's (Specify only highest of Elementery/Secondery (0-12)	Education grade completed) College (1-4or 5-	(9	ecedent's Usu Give kind of wo ife. DO NOT u	el Occupat ork done du se retired)	ion tring most of	working	16b. Kind of Bu	usiness/Industr	У	
The star	12th Grade		E	lectron				U.S.			
Be system	17. Father's Name (First, Middle, La				1		Name (First, Middle, M	Aaiden Suman	re)		
Went Went To Ite	Hubert	Schul	Z			Anas	tasia Ke	rner			
nd 2 sho lifth and 1 27 is ma r frauma	t9a. Informant's Name/Relationship Leonora Schulz			-			r Rural Route Number ve, Lexing				
Pages 1 a ant of Hea ht. If Illern ry or othe	20e. Method of Disposition  1 Buriel 2 Cremation 3  4 Donation 5 Other (Spe		20b. Place of D cemetery, Brinsfie			)	Dec. 21	20c. Location -		Stete, Maryla	
Departm Departm Importa any inju	21. Signature of Juneral Supplies	21000		22. Name a Brinsf	d Address		al Home, P	.A.	10157		
3.00 P. C. C.	23a. Part1. Enter the disease, or co	sfield, Jr.	MUUU52	P.O. E	ox 2/	9, Le	onardtown,	Maryla		50 proximete	
	shock, or heert failure. List or	ly one cause on each lin-	9.			, , , , , , , , , , , , , , , , , , , ,			Inte	erval Between set and Death	
Physician Medical	Immediate Cause (Final	0 4				•					
Examiner	disease or condition resulting in death)	a. TROBX	ble 11	4004	2011	46	INFARC	100		sec	
-			Due to (or as e co	nsequence of)							
n and ial-transit		b									
and and II-trar	Sequentially list conditions, if any, leading to immediate		Due to (or as e co	nsequence of)							
ceta be executed physician and stha burial-transit edical Examir	Ceuse (Diseese or Injury	c									
ng physicia as tha bu	that initieted events resulting in deeth) Last	C	ue to (or es e co	nsequence of):					1		
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e attendii of for use									1		
the ship hed 1	Part II. Other significant conditions	contributing to death bu	t not resulting in t	he underlying	cause giver	n in Pert t.	23b. Dld 10	bacco use co	ntribute to the	cause of deat	
ss that the death cartigoded by the attending be deteched for usa to by Physician/M	ASC	LVI)					1 T	es 2 No	3 Probabl	ly 4 Unkno	
been should	C01	0					24e. Was a perform	n autopsy ned?	eveilet	eutopsy findings ble prior to etion of cause th?	
certificate has rector, page 2	) u						10 Y	s 20 No	1 🗆 Ye	es 20 No	
or, p	25. Was case referred to medical	,				26 Place of	Death (Check only or	(A)		/1	
this certific ral director,	examiner?	Hospital:	nt 2 ER/Outp	atient 3 D	Other		ng Home 5 Reside		er (Snecify)		
rithis rall or T. T.	27. Manner of Death	28a. Date of Injury (Month, Dey			28c. Injury Work		28d. Describe h				
Afta Afta	t Neturel 5 Pending Investige		Year) Inj	ury M		7 es 2□No	-	-			
or Attanding after death. Director: After I in by the fune ertification	27. Manner of Death t Neturel 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury M V V V V V V V V V V V V V V V V V V V										
Medical Certification: To Be Com	29a, Certifier (Check only one) Certifying Medical Ex	Physician: To the best of aminer: On the basis of and manner stal	examination end/	death occurred or investigation	at the time	e, date and p nion, death	place, end due to the coccurred at the time, d	ause(s) and mate and place,	anner es state end due to the	d. cause(s)	
M M	29b. Signature and title of certifier	1		29	c. License	number	2	9d. Date signe	d (Month, Day	, Year)	
N. W.	> halk	m the			014	285		17.	-18-0	D)	
O CA	30. Name and address of person wh	no completed cause of de	eth (Item 23a) (T	vne Print)	0.7	- 0.3		10	110		
	William Boyd		(om zou) (1		ardto	wn, Ma	aryland 20	650			
State	31. Dete filed (Month, Pay, Year)		r's Signature			,	,				
	William Boyd	, MD			ardto	own, Ma	aryland 20	650			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 4251 Certificate of Death AMENDED #10g,12-13-00, DAN, ST. MARYS CO. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Yaar Month **Physician** Anna Schennach December 1, 2000 5:25 PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 8. Data of Birth (Month, Day, Year) **Funeral** Days 1□ M 2፟ F Hours Months Austria 442-48-1752 Director 98 June 25, 1902 Usual Rasidance of Dacedant the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits frems 23s or 28s-f show over must be notified at 1 ☐ Yas 2 ☐ No Maryland St. Mary's Director Piney Point 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda AUSTRIAN CITIZEN 16500 Piney Point Road Funeral 20674 12. Was Decadent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ②No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black. Whita, atc. filed within 72 hours after 1 Nevar Married 2 Married 21215-0020 ò 1 Yas 2 No Specify: White Specify: þ it. Pages 1 and 2 should be filed within research and Pages 1 and 2 should be filed within research and Menial Hygiene. 3 ☑ Widowad 4 ☐ Divorced "natural", Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) 5th Grade Collega (1-4or 5+) Homemaker Own Home Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Albuin Reind1 Judith Hasel Wanter 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Isabella McCracken (Daughter) 16500 Piney Point Road, Piney point, Maryland 20674 Baltimore, 20b. Piace of Disposition (Nama of 20a, Mathod of Disposition 20c. Location - City or Town, Stata Stremetery crematory or other place) lic Cemetery permit. Pages Department of Important: If It any injury or o 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 12/6/2000 Valley Lee, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Service Library Lawrence of Edward N. Brinsfill, Jr. M00052 Brinsfield Funeral Home, P.A. 20650 22955 Hollywood Road, Leonardtown, Maryland 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onsat and Daath **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Cardiac standstill (arrest) immediate Examiner Dua to (or as a consaquance of): Cardiac conduction (dysthythmia) years Physician/Medical Examine Dua to (or as a consequance of): leading to immediat Lenter Underlying a (Disease or Injury litiated events ing in death) Last Coronary heart atherosclerosis years Box 68760. Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. P.O. senility 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. þ 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed parformed? No 1 Yas 2 No 1 TYas 2 No 25. Was case referred to medical examiner? Be 26. Placa of Daath (Check only ona) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Othar: 4M Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: 28b. Tima of Division Attending 1. Natural 5 Pending after death. Director: Aft 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 Suicide 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide Descripting Physician: Toma best of my knowledga, daath occurred at tha tima, data and place, and dua to tha ceusa(s) and mannar as statad.

| Medical Examines: On he besis of examination and/or invastigation, in my opinion, daath occurred at the time, data and place, and dua to the cause(s) and mannar stated. 29a. Certifier To the P within 2 To the F 29c. Licansa number 29d. Data signad (Month, Day, Year) Rugerie Qua DU2159 December 4, 2000 30. Name and address of person who complated ceusa of death (Itam 23a) (Type, Print) Guazzo, M.D., Maryland Infirmary, Chaptico, Maryland Eugene 20621-0002 31. Date filed (Month, Bay, Year) 32. Registrar's Signatura State 5 2000 Registrat



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			State o	f Maryland		artment o rtificate			ind Mei		jiene () leg. No.	U	42514
81	_	1. Decedent's Name (First, Middle, L	ast)		3.000				2.	Date of Dea Month	th Day	Year	3. Time of Death
Physicia /Medica	ai	Manuela Clar	ziio	Saniua	n						er 5, 2		6:15 a.m
Examine	_	4a Facility Neme (If not Institution, gr 21944 Spring Val	ve street end nu	mber)					wn, or Locat gton P	on of Deeth	4c. County St. N		S
Funeral Director			Sex 1□M 2∏F	7. Age (In yrs. las	st birthdey) 95 Yrs.	If Under 1 \ Months D	Year	If Under : Hours	Min. M.	Date of Birth (Month, Day arch 2	7,1905	9. Birthp	plece (State or Forei
9		Usual Residence of Decedent											
la-f show	ctor	Maryland St. M	lary's	Lex	ingto	n Park							0d. Inside City Limi 1 ☐ Yes 2 ☒ N
23s or 2	al Director	10e. Street and Number 21944 Spring Va	lley Dr	ive		10f. Zip Co	653				Og. Citizen of V United		
	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Dece Armed Fo 1 Tes If Yes, Giv Yeer or D	2 No		Was Deceden If Yes, specify 1 ☑ Yes 2□					Blac	e - Americ k, White, White	
iene. Than 'netur The Medical	Completed	15. Decedent's E (Specify only highest g Elementery/Secondary (0-12)	ducation rede completed) College (	I-4or 5+)		dent's Usual C kind of work of DO NOT use i emaker	Occupa done d retired,	ation luring most	of working		16b. Kind of Bu		dustry
HO P	To Be C	17. Father's Name (First, Middle, Las Jose Clavijo G	•								<i>Maiden Sum</i> am ontero	Θ)	
27 is ma		19a. Informent's Name/Relationship Gisele P. Wright		daughter							r, City or Town, 1, Oklah		
trif item y or othe		20a. Method of Disposition  1 Buriel 2 Cremation 3  4 Donetion 5 Other (Spec		State Brin	ce of Dispo metery, crem isfiel	osition (Neme metory or othe d-Echo	of erplect	e) crema	12/7	72000	20c. Location - Charloti		own, State all, Maryl
Departm Importan any injur	-	21. Signature of Funeral Service Lice	1720	M01114	22						, P.A.,		55 Holly-
hysician /Medical :xaminer		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)		n gest Due to (or								1 1 1	Approximate Interval Between Onset end Death
sician and bunal-transit	Examiner	Sequentially list conditions,	b	Due to (of	as e consec	anterquence of):	J.	2).	sen	re		1	
nysicia he bur	Ca	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	c. H	Due to (or a	as a conseq	quence of):	ci	fre	Pals	nna	ing Di	sare	
ate has been signed by the attending of	Phy	Part II. Other eignificant conditione	contributing to d	eath but not result	ling in the u	inderlying cau	se giv	en in Part I			obacco use col	97.2	o the cause of dec
been	Completed by						Ė				en eutopsy med?	6/	fere autopsy finding vailable prior to empletion of ceuse deeth?
this certificate has ral director, page 2	E									1 🗆 Y	es 2 No	1	Yes 20 No
this certificanal director, p	Be	25. Was case referred to medical examiner?						26. Plece	of Death (	Check only o	ne)		
direce	2	1 Ves 2 No	Hospital: 1	Inpatient 2 E	R/Outpatier	nt 3 DOA	Oth	er: 4□ Nu	rsing Home	5 Resid	lence 6 Oth	er (Speci	(ty)
r death. actor: After th by the funeral		27. Manner of Deeth  1 Neturel 5 Pending investigation  28e. Date of Injury (Month, Dey Year)  28b. Time of Injury 28b. Time of Injury 4 Work?  1 Yes 2 No									now Injury occur		
after de l Diracto d in by th	Certification:	3 Suicide 6 Could not determine	286. Place	of Injury - At homing, etc. (Specify)	ne, ferm, st	reet, factory, o	office		281	Location (5 City or Tow	(Street end Number or Rurel Route Number, own, Stete)		
n 24 hou ne Funer pletely fil	29a. Certifier (Check only one)  1 Certifying Physician; To the best of my knowledge, death occurred et the time, date and place (Check only one)  1 Certifying Physician; To the best of my knowledge, death occurred et the time, date and place (Check only one)  1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner steled.												
Tott	Σ	29b. Signature end title of certifier 29c. Licen							9c. License number 29d. Date signed (M				Dey, Year)
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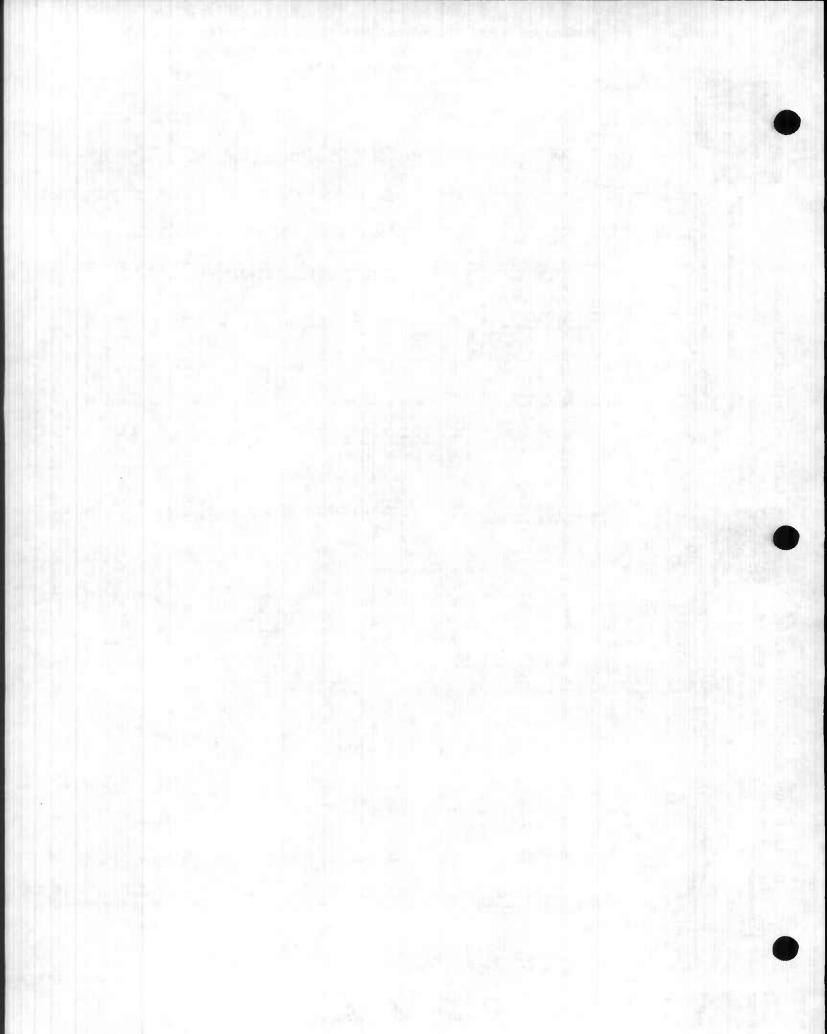
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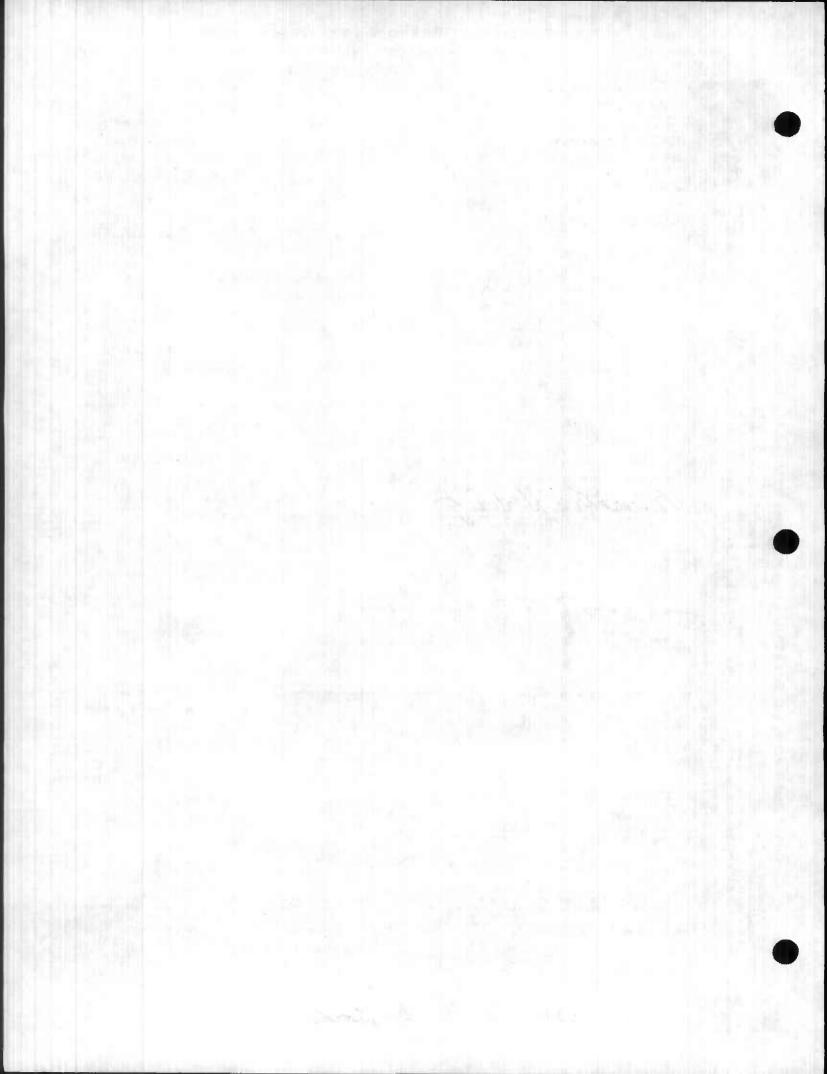
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State of Maryland / Department of Health and Mental Hygiene 00 42515

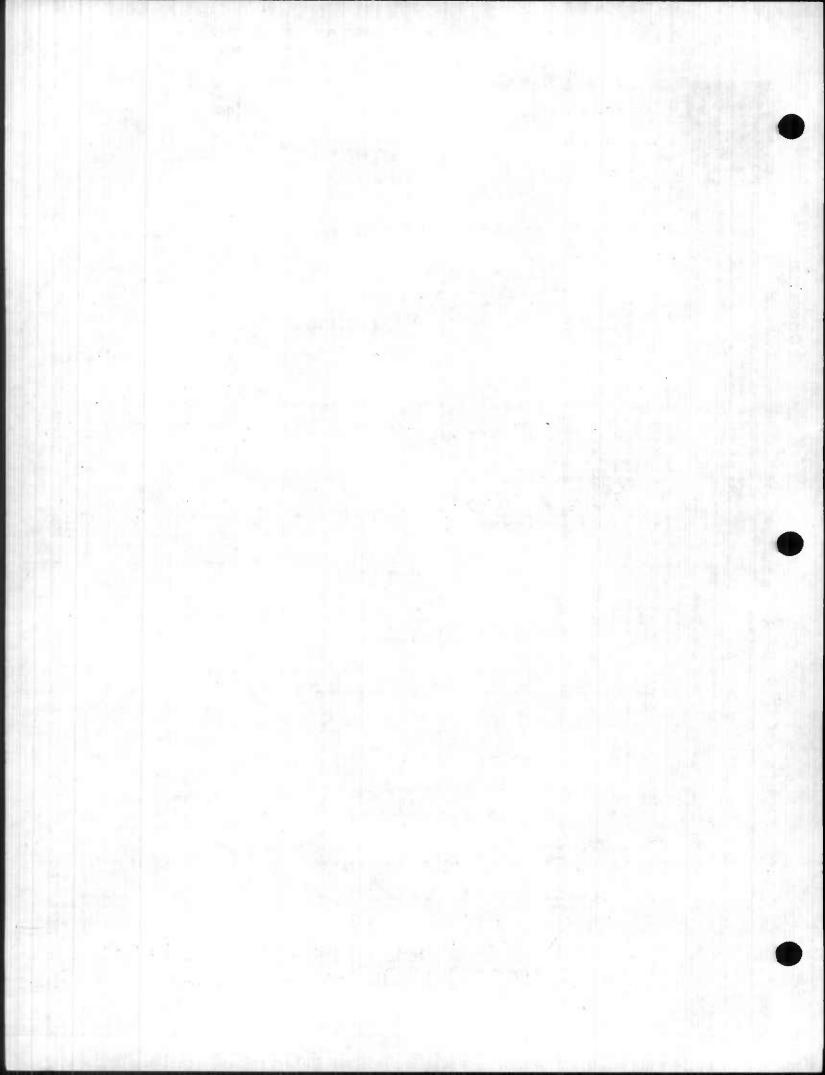
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led be feed of feed of	.0	Eugene Peace	ock						Co	ra M	cKay			
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20 0	Physician	Pert II. Other significant condit	ions cont	ributing to d	leath but not ra	sulting in tha	underlying	ceusa gi	ven in Part	t.	23b. Dld	tobacco use c	ontribute t	o the cause of death?
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f or Attending after death. Director: After din by the fune	at the	2 Accident invas	tigation				М	1	Yes 2	No				
Att de by t	E S	3 ☐ Suicida 6 ☐ Could 4 ☐ Homicide detar	mined	28a. Plac	e of tnjury - At I	noma, farm, s	treet, facto	ry, office				(Street and Nun wn, State)	ber or Rur	ral Routa Number,
To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:					,,								
hour hour ners y fille												ceuse(s) end n		
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	1.	Decedent's Nama (First, Midd	lla, Last)			Cel	uncal	e or L	Death		2. Data of C	Reg. No.			3. Tima of Deat
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	ŀ	Sinai Hospita	cal						3	alti	more	Ва	altin	nore	City
al		Social Security Number	6. Sex 1 ₩ M 2 □	1	a (In yrs. last	t birthday) Yrs.	If Unda Months	r 1 Yaar Days	If Undar Hours	24 Hrs. Min.	8. Data of 8 (Month, E	irth Day, Year)		9. Birthp	lace (State or Fore
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Irene Baynard

Baltimore, Maryland 21215-0036

Physicia /Medic Examir

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

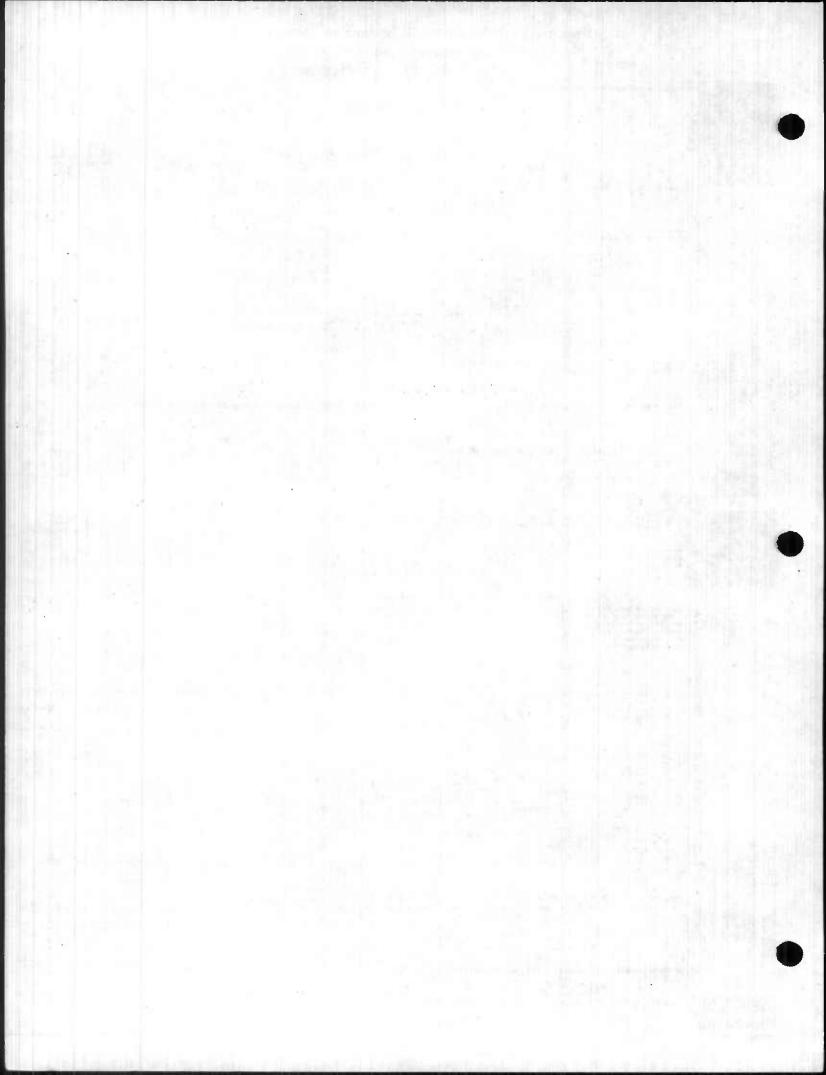
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the bunsartransit Division of Vital Records, P.O. Box 68760,

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The Memorial	Hospita	a1				East	ton			Talb	ot	
5. Sociel Security Number 6. Se	ex 7. Age		last birthday)	If Under 1 \		If Under 24		Date of Birt (Month, Da	h v Yaar)	9. Bir	thplace (State or Fountry)	
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MD Carol	line	Toc. City	y, Town or Loc	attori		Fede	ral	sburg	}		10d. Inside City	
10e. Street and Number				10f. Zip Co	ode		1 34		10g. Citizen			
27035 Iron Gat	te Road				2	1632			Unite	ed S	tates	
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3 Widowed 4 Divorced	Year or Dates:		16a Daged	ont's Herrel C	Jacusco	tion			16h Kind o	Kind of Business/Industry		
15. Decedent's Edu (Specify only highest grad	de completed)		16a. Decede	ind of work of ONOT use	done du	ining most of	f working	,	160. Kind 0	d of Business/Industry		
Elementery/Secondary (0-12)	College (1-4or 5	5+)	Labo		1011100/				Pack .	king Companie		
17. Father's Name (First, Middle, Last)						18. Mother's	Neme (	First, Middle,	name)			
	Norma	n Ba	ynard				Cla	ra Fi	sher			
19a. Informant's Name/Relationship (T	nd Number o		Route Numb	wn. State.	Zip Code)							
Albert Baynard							g, MD 2					
20a. Method of Disposition		20b. P	Place of Dispos	ition (Name	of		T.u.	Date			Town, State	
1 ☑ Buriel 2 ☐ Cremetion 3 ☐		C	emetery, crem	atory or othe	er place		12	/27			on, MD	
4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licens	·	30		Name and A			12	1 4 1	111 • L	CIIC	011, 110	
	- A		F	rampt	om.	-Hawk						
Framptom-Hawkins-Eskow Funeral I PO Box 43, Federalsburg, MD 2163  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, in the disease or each line.												
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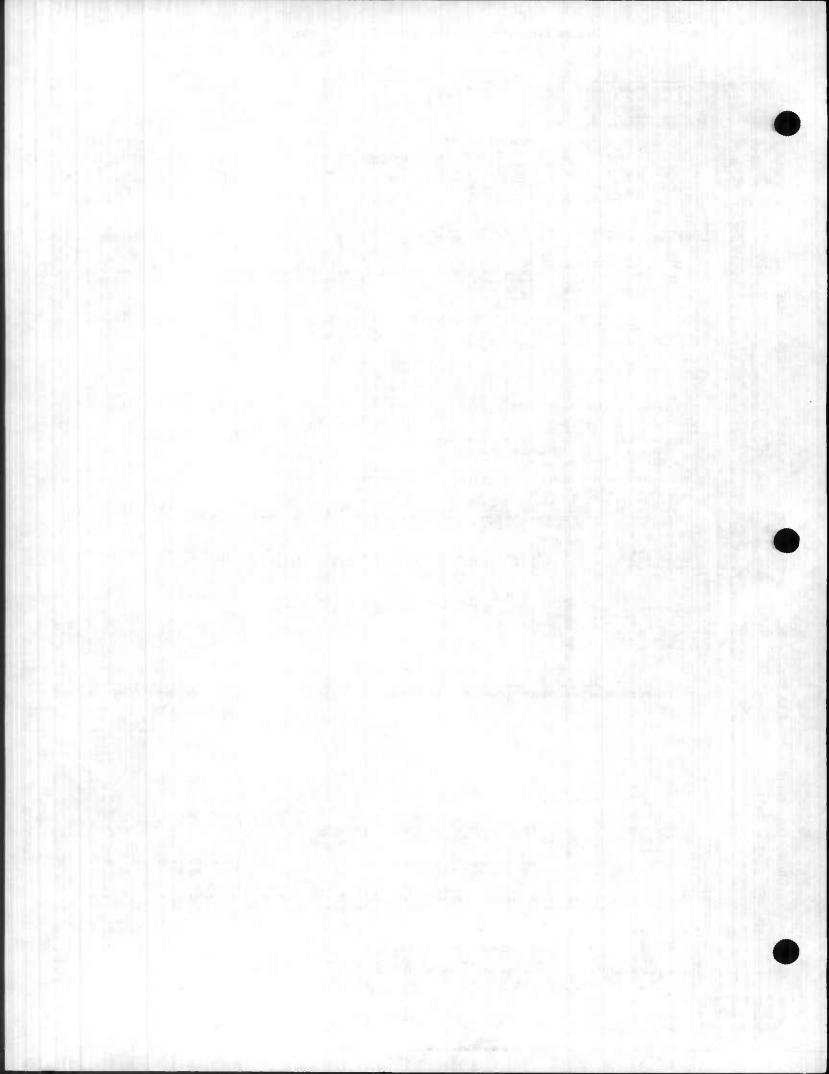
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State of Maryland / Department of Health and Mental Hygiene 00 425 18

					Ce	rtificate d	of L	eatn			Reg. No.			
Physician	_	Decedent's Nama (First, Middla, L     Educa	Bernin	i Sella	ıre					2. Dala of D Month Decem	Day ber 21,	Year 2000	3. Time of Death 9:55 pm	
/Medica Examine		4a Facility Nama (If not institution, g Residence: 4310			ım Road		4b			cation of Dea	Ih 4c. County		ord	
Funeral Director			Sex		s. last birthday Yrs.	If Under 1 Y	aar	If Undar Hours			irth (Year) 20,1925		placa (Stata or Foraign http: Italy	
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3a or 3		10e. Street and Number 4310 Webster-Lap:	dum Roa	ıd		10f. Zip Coo		1078			10g. Citizen of \	S.A.	nry :	
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"natural", or its	ted by	₩Widowed 4 Divorced  15. Decedent's I	Yaar or E	Datas:	16a. Dece	edant's Usuel Oc	ccupat	tion	a of world		16b. Kind of B		White	
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end Menidite marked		19a. Informant's Name/Ralationship	(Type, Print)	1215	19b. Mail	ing Addrass (St	reet a	nd Numbe	er or Rura	/ Routa Num	ber, City or Town,	Stata, Zip	Code)	
other trau		Ann R. Wagner (D	aughter)						um Ro	oad, H			, MD 21078	
Peges 1 nent of He nt: If Itan iry or oth		20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spec		SIBIR		osition (Nama d Imatory or other Memoria			ns 1	Data . 2/23/0	20c. Location -	+	Maryland	
permit. Pege Department of Important: If any injury or pace.		21. Signature of Funaral Sarvice Lice	ensee	<-			Pat	ters	on &		uneral H		P.A.	
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11		30. Name and address of person wh	completed cau	sa of death (III	om 23a) (Type	Print) 211	2	DE10	-Ank	MA	RYLAN	/D .	21047	
State Registra		31. Dala filed (Month, Day, Year)	General 32. 1	Registrar's Sig	patura	racks			1		V		/	



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 22:30 Scott December 20, 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Bayside Care Center Lexington Park St. Mary's If Under 1 Year | If Under Months | Days | Hours Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months 10 M 20 F Yrs. Director 214-36-2013 60 April 11, 1940 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland 1 Ves 2 No Director St Mary's Lexington Park 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21412 Great Mills Road 20653 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. be filed within 72 hours after 1 Never Merried 2 Married 1 ☐ Yes ZV No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: P White 3√ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Secretary US Government Pages 1 and 2 should be filed a nent of Heelth and Mental Hygicint: If item 27 is marked other 1 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel W. Kidwell Inez Eva Kidwell 19a. Interment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wesley S. Kidwell (Brother) 11518 Terrace Drive Waldorf, MD 20602 20a. Method of Disposition

1 SpBrial 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete permit. Pege Department of important: If any injury or once. Oakland Cemetery 12-27-00 Waldorf, MD 21. Signature Funeral Service Licensee 22. Name end Address of Facility M00173 Eberwein Funeral Services 4433 White Pls. La. White Pls., MD 20695 Detwe 234 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediete Cause (Finel disease or condition resulting in deeth) Examiner Examiner physician and s the burial-transit requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760. Physician/Medical Due to (or as a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably MUnknown 3 1 Yes 2 No signed b Records. þ 24b. Were autopsy tindings eveilable prior to Completed 24a. Wes en eutopsy performed? completion of cause of death? page 2 : 1 Yes 20No 20 1 Yes certificate Division of Vital director, 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Neturel
Accident Attending 5 Pending investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune. 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner steted. 29a. Certifier Medical (Check only one) 29b. Signeture and title of parts 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme end ad no completed cause of death (Item 23a) (Type, Print) James C. Boyd, MD California, Maryland 20619

DHMH 16 Rev 6/95

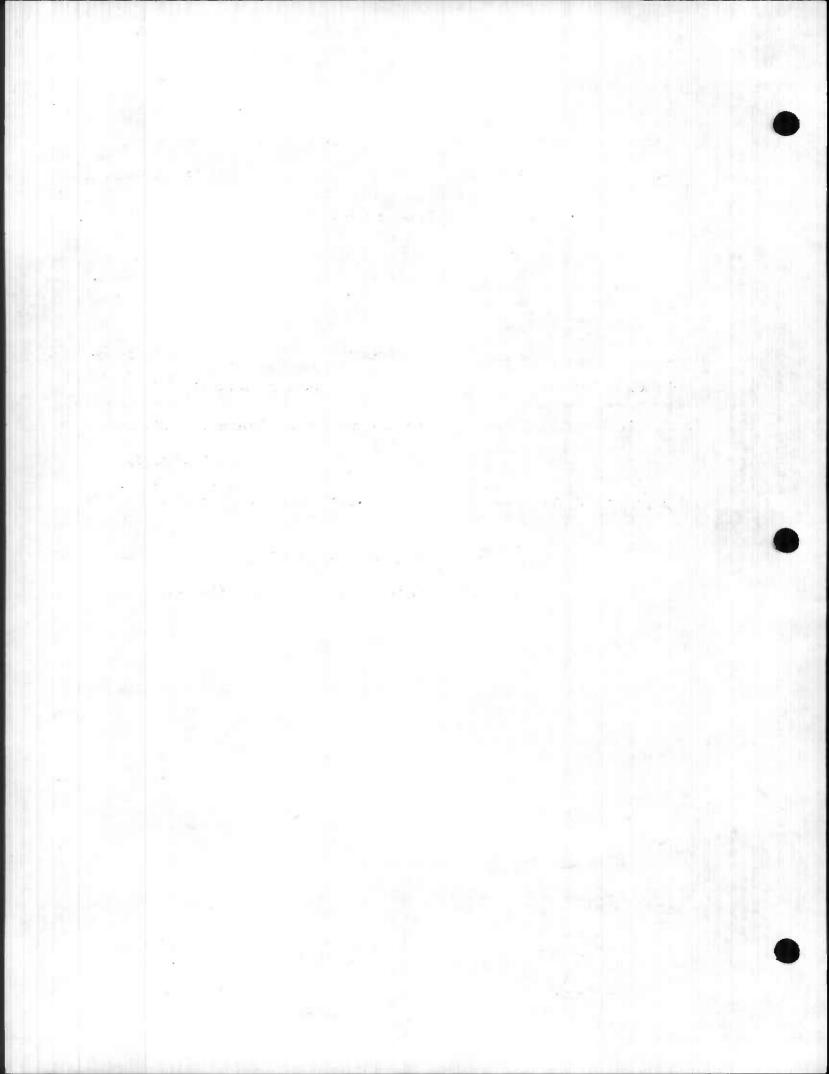
State

Registrar

31. Dete filed (Month, Day, Year)

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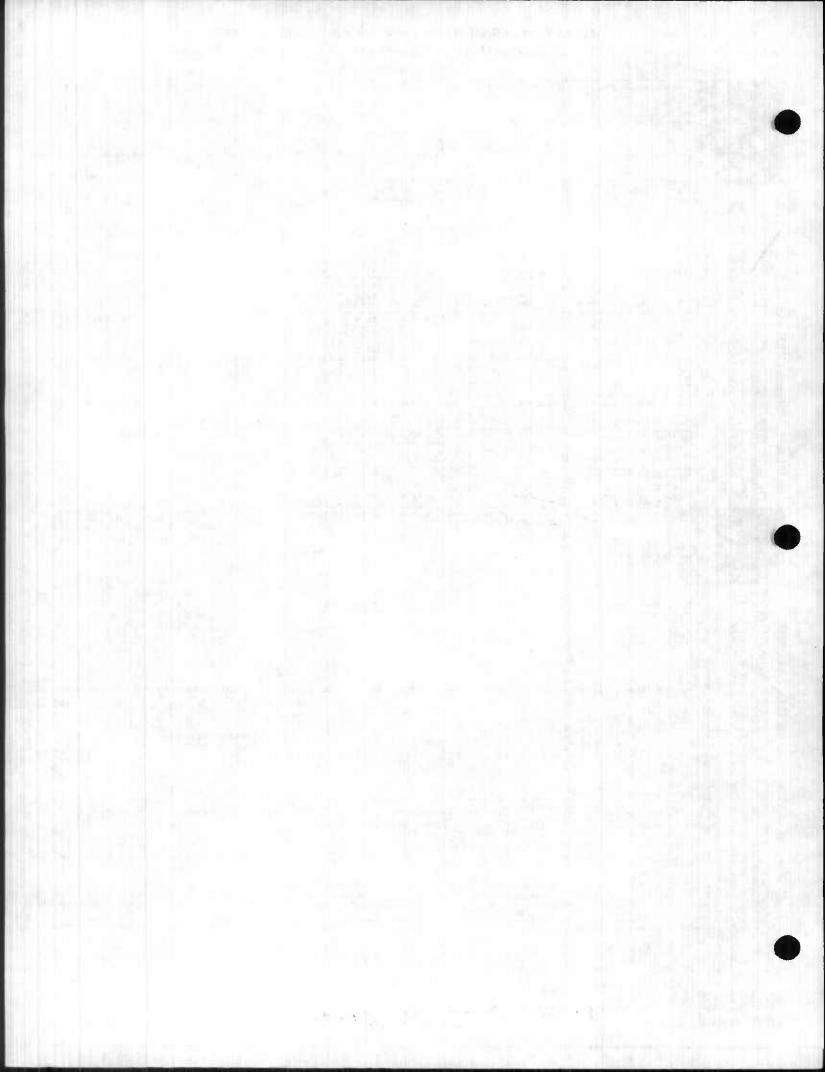
32. Registrar's Signeture



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State of Maryland / Department of Health and Menta	al Hygiene	r.b	6.	J	6
Certificate of Death	Reg No				

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40	Physiciai /Medica	_	Agnes				Sla	ter			Decemb	er 16,	2000	11:00pm
	Examine	_	4a Facility Nama (If not institution,	- SHARE						4b. City, Town, or	Location of Death	1		
			Manor Care  5. Social Security Number	Heal			es last birthday)	H Und	er 1 Yaar	Largo	9 Date of Bird	Princ	ce G	eorges
	Funeral Director		215-36-4800 Usual Residence of Decedent	1 M		69	Yrs.	Months		Hours Min.	8. Date of Bird (Month, De July 1	1,1931	9. Birnp Coun Mary	place (Steta or Foreign http) Land
	Bu Bu	-	10a, State 10b. County			10c. Cit	ty, Town or Lo	ocation					1	0d. Inside City Limits
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	th with the Maryla 23a or 28a-f shov ust be notified at	* -	10a. Street and Number 2932 Hutter		Way				ip Code			10g. Citizen of V		itry?
The state of	ms 23	90.0	11. Marital Status	12. W	/es Decede	nt Ever in U	I,S. 13.			Hispanic Origin? (S can, Mexicen, Puer	Specify Yas or No	U.S.A	a - Americ	can Indian,
020	72 hours after natural, or its fical Examina	by rui	1 □ Never Married 2 □ Marrie 31○31√31√31√31√31√31√31√31√31√31√31√31√31√3	ed 1	rmed Force ☐ Yes 2( Yes, Give 'aar or Date	No				Specify:	to Hican, etc.)		Blac	
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yla		0	Joseph				Este	_		Marie			hing	
Var	d a st		19a. Informant's Name/Relationsh							t end Number or R				
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mor	II He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Ramo	val from Sta	ite	cemetery, crer	metory or	othar ple					
=	nime n	-	4 Donation 5 Other (Sp. 21 Signature of Fineral Service L	-	1	St	.Peter			ess of Fecility	2/2000	waldor	T Me	aryland
Ba	Depu		TVNAV 6	3	/		_							
F	Physician		23a Part1. Enter the disease of shock, or he in failure. List of	complication on the complete o	ns that below use on mac	sed the dear	th. Do not ent	ter the mo	ode of dy	al Home	c or respiratory a	rrest,	Mary	yland 2060 Approximate Interval Between Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):										hour		
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ć	an an rial-tri		Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or Injury		LI.			1	,	/ •			1	hours
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Вох	eath cer attendin I for use	and		d										
Ċ.	bed f	Physician	Part II. Other algnificant condition	s contribu	ting to deat	h but not res	sulting in the u	inderlying	ceuse g	iven in Part I.	23b. Did	tobacco use col	atributs to	o the cause of death?
P.O.	uires that the de signed by the a id be datached f	E	diahetes								10	Yes 2□ No	3 Pro	bably 419 Unknown
of Vital Records,	law requires that the death certificate be executed as been signed by the attending physician and a should be datached for use as the burial-transit	Completed by	diabetes Hypotensis	٦ .								en autopsy ormed?	av	ere eutopsy findings vailabla prior to empletion of ceuse
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1900	i or Attending Patter death.  Director: After d in by the funer.	Certification:	2 Accident investig 3 Suicida 6 Could n 4 Homicide determi	ation ot be	Be. Place of building,	Injury - At h , etc. (Special	ome, farm, str	M reet, facto		Yas 2 No	28f. Location ( City or To	(Street end Numb wn, Stete)	er or Rur	el Route Number,
		edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	xaminer: (	n; To the be On the besigned manner	s of examina	owledge, death ation and/or in	h occurre vestigation	d at the ton, in my	time, date and plac opinion, death occ	e, and dua to the urred at the time,	cause(s) end me date and place,	inner as s and due t	itated. o the cause(s)
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		-	30. Name and address of person v	no comple	ted ceuse o	of death (Iter	m 23a) (Type,	Print)			V 5 5 5	Curren	(nan	20902 NG MD
			ROINTAN F.	ARAH	1	R. C	18010	seo.	gia	Ave Su	it 3-35	JILVER	SPEII	VG MD
	State	?	31. Date filed (Month, Day, Year)	2000	32. Reg	istrar's Sign	ature L		1					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** ELISE SCHUKRAFT 11:25 p.m 2000 Dec /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Lutheran Village Westminster Carroll If Undar 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F Yrs. Director 212-32-4451 June 12, 1908 Germany Usual Residence of Decedent 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits r than "natural", or hame 23s or 28s-f show the Medical Examiner must be notified at Yes 2 No Director Westminster Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? Carroll Lutheran Village Heathcare Ctr 200 St. Lukes Circle

11. Marital Status

12. Was Decedant Ever in U.S. Armed Forces? United States 21158 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. after 1 Yas 2 No It Yes, Give Yaar or Datas: 1 Navar Married 2 Married Baltimore. Maryland 21215-0020 1 Yes 2 No Specify Specify: þ a Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filled with Department of Heelth and Mentel hygien, important: If than 27 is marked other that any Injury or other traumets. Homemaker Domestic 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) 8 Sophie Johann Sessler 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3723 Valerie Carol Ct, Ellicott City, MD Edwin C. Schukraft/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ₽ Burial 2 □ Cremation 3 □ Removal from State Evergreen Memorial Gdns 12/18/00 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 91 Willis Street Myers Funeral Home Westminster, MD 21157 23a. Part1. Enter the disease, or compilications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line: Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final . End Seege Concerture Heavy Pailure Comos disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last and Due to (or as a consequence of) physicien Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 0 signed by t 1 Yee 2 No 3 Probably 4 Unknown ۵. Division of Vital Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy 20 No 1 ☐ Yes 2 ☐ No certificate 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28a. Date ot Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending Investigation or Attanding 1/ Natural 2 Accident within 24 hours after deeth. To the Funeral Diractor: At 1 Yes 2 No 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, dead occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edicai (Check only one) \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar 30. Name and address of parts

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31. Date filed (Month, Day, Year)

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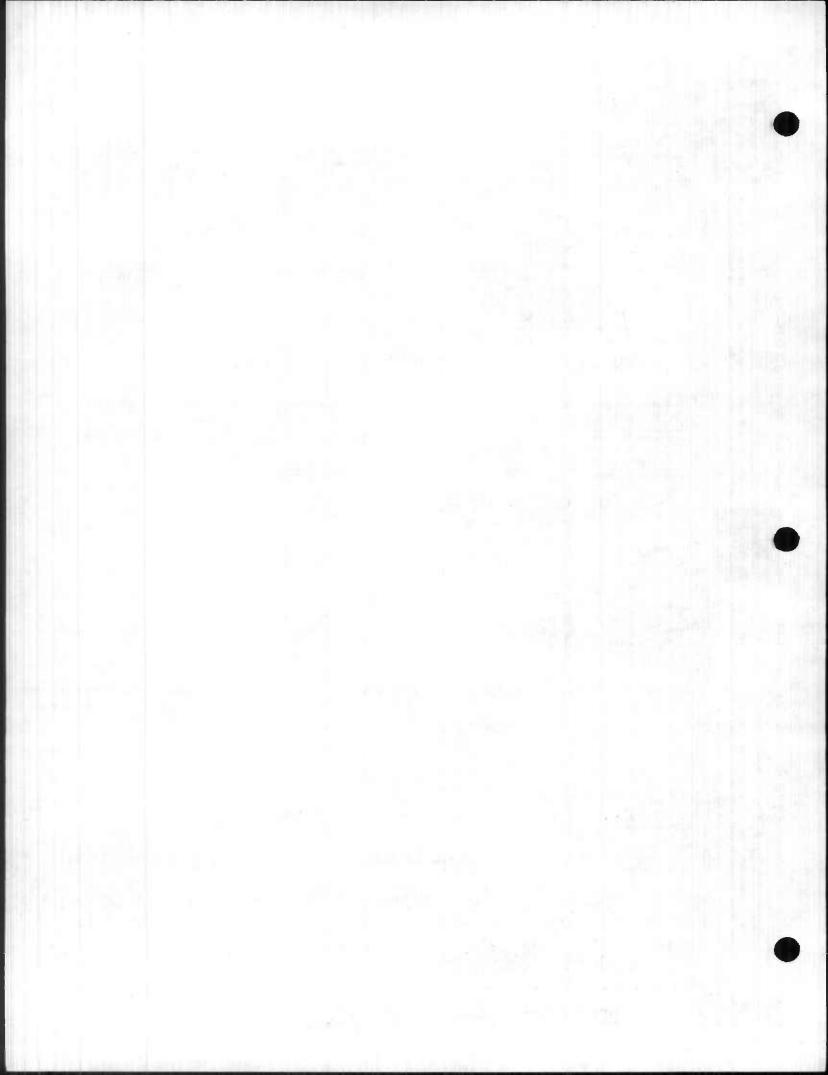
32. Registrar's Signatu

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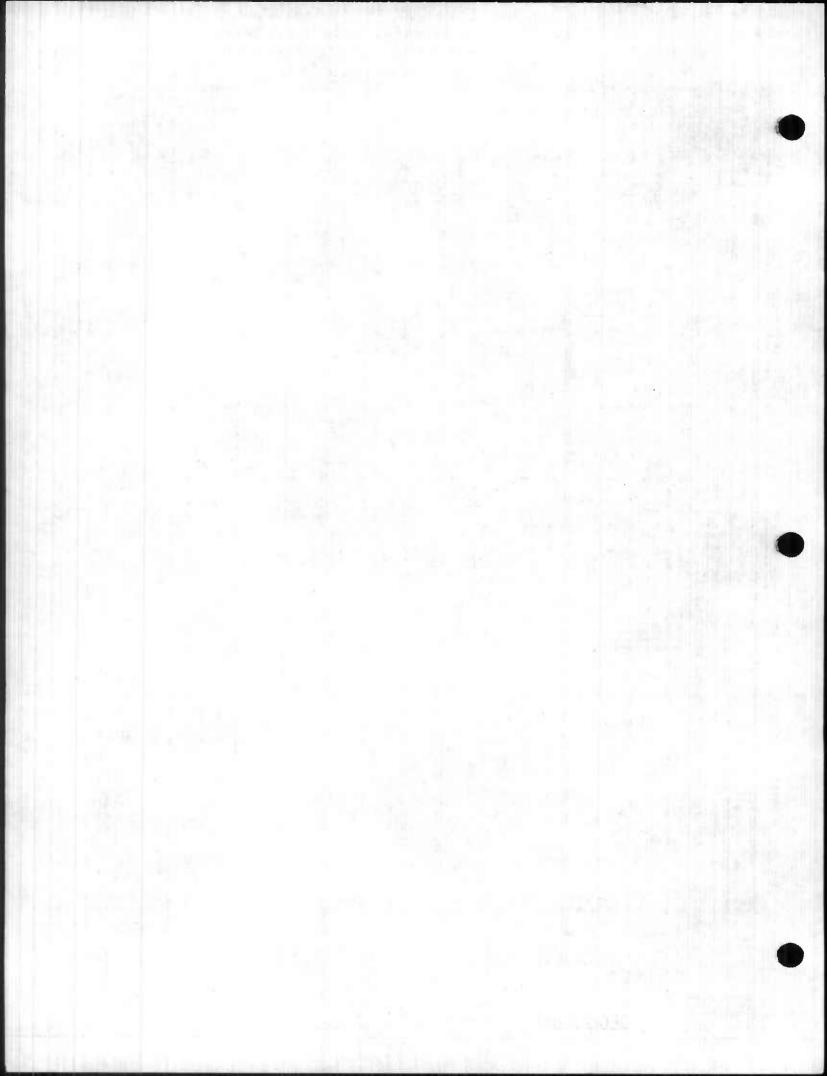
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State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Yaar **Physician** 15, December 2000 4:05 PM Richard Henry Shoemaker /Medical 4a Facility Nama (tf not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Undar 24 Hrs. 8. Dala of Birth
Hours Min. 8. Dala of Birth
(Month, Day, Yaar)
Sept. 30, 1933 If Under 1 Yaar 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days Months 113⋅M 2□ F Yrs. 219-30-2546 67 Maryland Director Usual Rasidance of Decedent the Maryland 10a, Stala 10b. County 10c. City, Town or Location 10d. Inside City Limits frame 23e or 28e-f above near transfer be notified at 1 Yas 2 No Maryland Frederick Woodsboro Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? with 633 W. Adams Circle 21798 U.S.A. death Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 (\$\fomale Yas 2 \subseteq \text{No} \text{If Yas} 2 \subseteq \text{No} \text{If Yas}, \text{Giva} \text{Yaar or Datas}: 1952-56 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status the Medical Examiner Black, Whita, atc. 72 hours after 1 ☐ Nevar Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yas 2 ☑ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada completed) d 2 should be filed within 72 th and Mental Hygiena. 7 is marked other than "na Elemantary/Secondary (0-12) College (1-4or 5+) maintenance 10 painter 18 Mothar's Nama /First Middla Maidan Sumama) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic avant 17. Father's Nama (First, Middle, Last) Rodrick L. Shoemaker Ruth Favorite 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary J. Shoemaker / wife 633 W. Adams Circle Woodsboro, MD 21798 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Circremation 3 Removal from Stala 4 ☐ Donation 5 ☐ Other (Specify) 12/18/00 Hampstead, MD CarrollCremation, Inc. 21. Signature of Finaral Service License 22. Nama and Address of Facility Hartzler Funeral Home Merine 404 S. Main St. Woodsboro, 23a. Part1. Enlar tha diseasa, or complications that odused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical 30 spiration NVmIni Examiner Due to (or as a consequence of) /mo Examiner acciden rebovorenta physician and the burial-transit daath certificata be asscuted Sequentially list conditions, if any, laading to immediate causa. Entar Underlying Cause (Disaase or injury Dua to (or as a consequence of): Box 68760 edical that initiated evants rasulting in death) Last Dua to (or as a consequance of): 82 Physician/M USB 5 ed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? The law requires that the Yes 2 No 3 Probably 4 Unknown ۵ abetwetive rulmoha signed t N15003e Division of Vital Records, P 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy peen has na 2 s page 215,No 1 ☐ Yas 1 □ Yas 2 □ No certificata Physician: 25. Was casa ralarred to medical examinar? director, Be 26. Place of Daath (Check only ona) Hospital: 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) To 12 Impatient 2 ER/Outpatient 3 DOA this funaral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? To the Hospital or Attanding Pi within 24 hours after death. To the Funeral Director: After th complately filled in by the funera Certification: Aftar 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 ☐ Accident 6 Could not be detarmined 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifiar (Check only one) 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signad (Month, Day, Year) 1) ) / 157 ew 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) Woodshin Mi) Ash 10201 Cillermine 31. Data liled (Month, Day, Year) 32. Registrar's Signatura State

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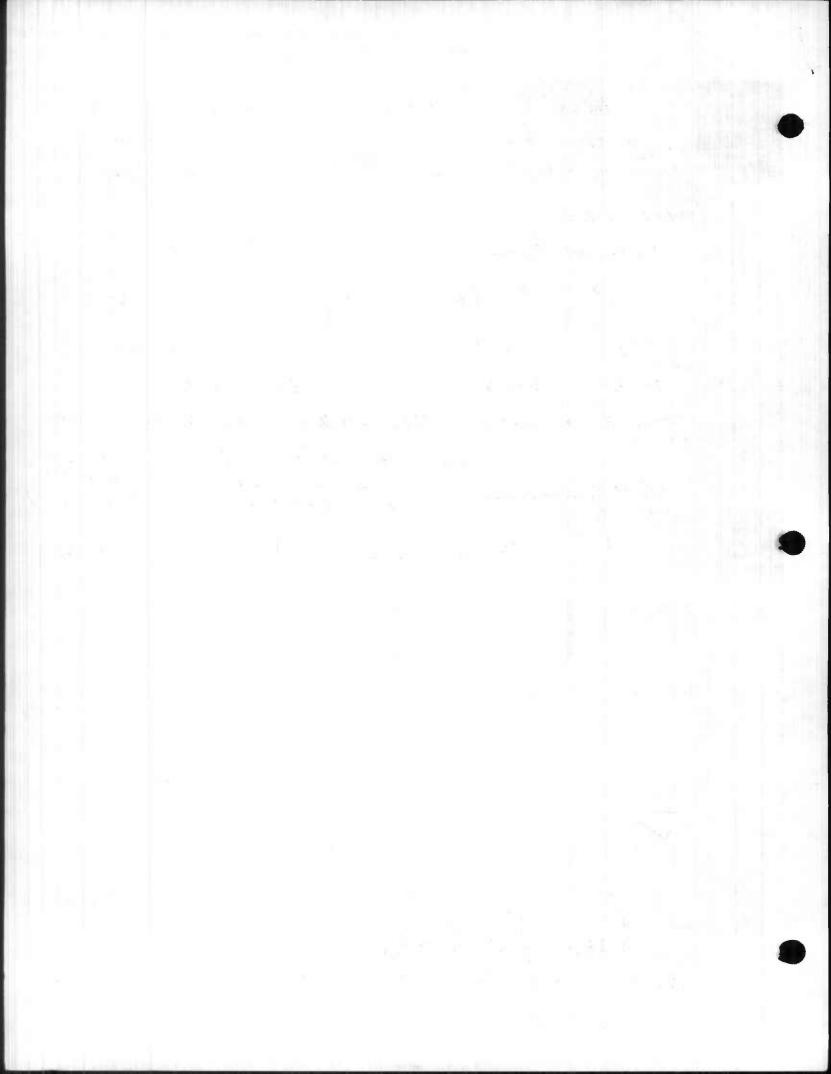
**ORIGINAL** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend Item 25 per Phy. State of Maryland / Department of Health and Mental Hygiene 12/18/2000, Carroll County, wj1 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Hewa 16 AM December 2000 /Medical 4a. Fecility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Avenue 322 Sykesville (Arroll If Undar 1 Year Months Deys If Under 24 Hrs. Hours Min. 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) **Funeral** 12 M 2 F 230-20-8910 2 Yrs. Director Nov. 18, 1928 irginia Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours after death with the Manylen Depertment of Health end Mental Hygiene. Together 10 Health and Mental Hygiene. Important: If line 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventment must be notified at 10d. Inside City Limits Maryland (Arroll 1 Yas 2 No Sykesville Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? CArl U.S. A. venue Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 11. Marital Status 14. Rece - American Indian, Black, Whita, atc XYas 2 No Yes, Give 1946 - 1947 eer or Dates: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify Specify: White Àq 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Transportation Truck Oriver 17. Fethar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Newton Leva Davis OL 19a. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Sykesville, Maryland 21784 Sayers/Wite Darah 20b. Plece of Disposition (Nema of cemetery, cremetory or othar place, 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 Buriel 2 Cremetion 3 Removel from Stata 4 Donetion 5 Other (Specify) 12/20/2000 Sykesville, Maryland Lake View Memorial Park 22. Name and Address of Facility
Jeffrey N. Zumbrum Funeral Home + Monument Co. 21. Signeture of Funeral Service Licenses 23a Fart. Enlar the disease, or complications that causad the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Eldersberg, Maryland 21784 Approximeta Interval Betwean Onset and Deeth Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) C mo Examiner Due to (or es e consequence of) Examiner physician and the buriel-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting In deeth) Lest Due to (or es e consequence of) Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of) 980 signed by the et d be detached fo Pert II. Other algnificant conditions contributing to death but not resulting In the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No λQ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? peen has certificate 1 ☐ Yes 2 0 0 N/6 1 ☐ Yes 2 1 No Division of Vital To the Hospital or Attanding Physician: within 24 hours efter death.

To the Funaral Diractor: After this certifice funeral director, 25. Wes cese referred to medical examinar? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Présidence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 1 Maturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

| Medical Exeminer: On the best of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature ar 29c. License number 29d. Deta signed (Month, Dey, Yeer) 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 5555. Center Street Westminster, Maryland 21157 UR. Flavio Krutek 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature State Registrar



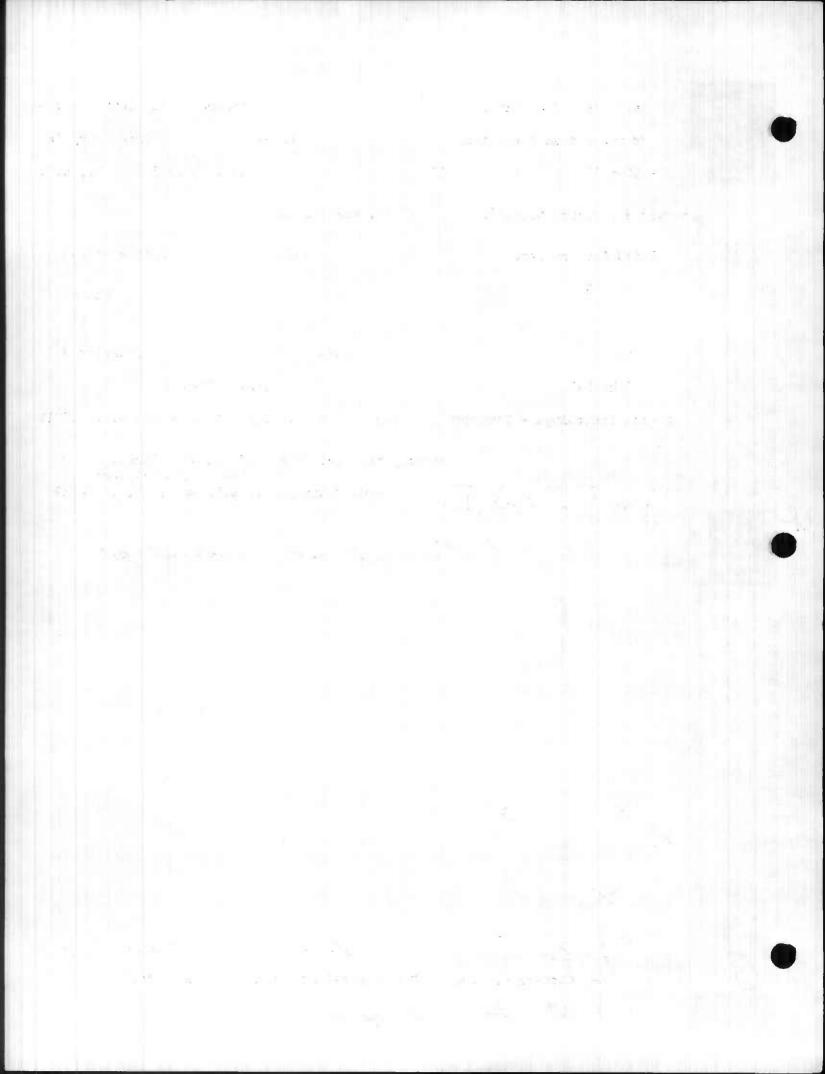
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Director		348-14-8308	1□M 2ØF	75	Yrs. Month	Days	Hours Min.	August ]	2, 1925	Country) Illinios
D .		Usual Residence of Decedent  10a. State 10b. County		10c City Toy	vn or Location					10d. Inside City Limit
with the Maryland a or 28a-f show	5	MD Wicomic	30		isbury					XXYas 2□N
the M	rect	10e. Street end Number	30	Du.		ip Code			10g. Citizen of V	Vhet Country?
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ter death terms 23	nera	11. Maritel Status	12. Wes Decedant	Ever in U,S.	13. Was Dec	edent of H	ispanic Origin? (Sp on, Mexican, Puerto	pecify Yes or No-		e - American Indian,
72 hours after netural", or its		1 Navar Marriad 2 Married	Armed Forces  1  Yes 2 1			20 No	Specify:	Hican, etc.)		k, Whita, etc.  White
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0 % D %	0 0	James P		Casey			Edna	Dage		
4 DEE	F	19a. Informent's Neme/Reletionship			b. Mailing Addre	ss (Street	and Number or Rui	Brya ral Route Numbe		State, Zip Code)
CENL		John Stevenson-	Son		L0406 He	adly	Court, F	airfax,	VA 2203	32
-155		20e. Method of Disposition		20b. Plece	ot Disposition (N	ame of	ce)	Data	20c. Location -	City or Town, State
Peges nant of int: If it		1 ☐ Burial 2 ♣ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spec			sbury Cr		1	2/18/00	Salisbu	ry, MD
permit. Pege Department Important: If any Injury or pace.		21. Signature of Funeral Styvice Lic	ensety /	7	22. Name	and Addre	ss of Fecility	ome, Pro	fession	nal Association
89 E E 8		1 Usu A	Lella.	-			Hill Road			
		234 Part1. Enter the disease, or co hock, or heart tellure. List on	mplications that cause	d the beath. Do						Approximeta Intervel Between
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attending for use as	N/W		d							
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8 6 8	Completed by Physician/Medical		No. 1945, No.	1200						Odb Wass sutansu tinging
been sign	etec								an eutopsy med?	24b. Were autopsy tinding available prior to completion of cause
8 0 N	du		Lam Esta							of death?
E # 8								101	res 2 No	1 ☐ Yes 2 ☐ No
certificate rector, pag	Be	25. Was case reterred to medical examiner?	Hospitai:			Oth	28. Place of Dee			
5 00	T. To	1 Yas 2/2 No 27. Menner of Deeth	1 Inpat		Outpatient 3 1	JUA	4   Ruising H	ome 5 Resident	tence 6 Oth	
E e	Certification:	1 Naturel 5 Pending	28e. Dete of Inj (Month, Do	ay Year)	Injury	28c. Injui Woi	k? Yes 2□No	202. 0000100		
Attending ir death. betor: After by the fune	flca	3 ☐ Suicide 6 ☐ Could not		jury - At home,	ferm, street, fect			28t. Location (S	Street and Numb	per or Rural Route Number,
	ert	4 Homicide	building, e	(c. (Specify)		2.5%		City or Tox	vn, State)	
d in die	9	29e. Certifier Certifying F	hysician: To the best	ot my knowledg	e, deeth occurre	d et the tir	ne, date end plece	end due to the	cause(s) and me	enner as stated.
hours afte meral Directly filled in	65	(Check only 2   Medicat Ex	end menner s	or exemination a leted.	nd/or investigetion	on, in my c	pinion, deeth occui	rred at the time,	dete end plece,	and due to the cause(s)
he Hospital or in 24 hours afte he Funeral Diri pletely filled in	edical	one)			2	9c. Licens	e number	E 30 3 15	29d. Date signe	d (Month, Day, Year)
To the Hospital or Attanding Ph within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	Medica	29b. Signeture and title of certifier								
To the Hospital or Attendition 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medica	one)	_ mo		2354	20	54127		12/	17/00
To the Hospital or within 24 hours after To the Funeral Dirt completely filled in	Medica	one)		daeth (Item 23a	(Type, Print)	20	54127		12/	17/00
To the Hospital or within 24 hours after To the Funeral Dire completely filled in	Medica	29b. Signeture and title of certifier	completed cause of	daeth (Item 23a) 3 B1 rer's Signature	(Type, Print)	Do	54127 d Deh	mar 1	12/ no -	17/00

Bearing & Syram

DEC 2 o 2000

State of Maryland / Department of Health and	Mental Hygiene
Certificate of Death	Reg No

		State of Maryland / Department of Health and Certificate of Death		ene (	) 4	2525
Dhusis		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Deeth
Physic /Medi		Betty Jean Scutchings	December	18	2000	10:00AM
Exami	ner		r Location of Deeth	4c. County		
		Prince George's Hospital Chev  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hi	erly			eorge's
Funeral Director		579-58-8211 1 M 2 F 55 Yrs. Months Deys Hours Mi		Yea <i>r)</i> 1945	Wash	ace (State or Foreign iry) 1., D.C.
e Marylend	ctor	Maryland Prince George's 10c. City, Town or Location Ft. Washington			10	od. Inside City Limits 1 □ Yes 2 □ No
th with th	ai Dire	10e. Street end Number 12513 Lampton Lane 10f. Zip Code 20744	10	g. Citizen of V Unit	What Count	
d 21215-0020 Illed within 72 hours efter deeth with the Maryland Wysiene. ther then "natural", or flams 23a or 28a-1 show out, the Madical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 Yes, Specify Cuban, Mexican, Put If Yes, Specify Cuban, Mexican, Put If Yes, Specify Cuban, Mexican, Put If Yes, Specify:  1 Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)		ck, White, e	
21215-0020 d within 72 hours ef giene. r then "neturel", or	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of wife. DO NOT use refired)	vorking	6b. Kind of B	usiness/Ind	ustry
illed with Hygiene.	Be Con		ame (First, Middle, N		E-Emp]	Loyed
Ald be fente ked a ked	To B	John Hill	adie Aller	n		
Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filed within 72 ho Department of Heelih and Menlal Hygiene. Important: If I fem 27 is merked other then "natur any highry or other treumetic event, in a viscal page.		19a. Informant's Name/Reletionship (Type, Print)  Sheila Scutchings - Daughter  19b. Mailing Address (Street and Number or 645 - 46th St., S				
Baltimore, Nomit: Pages 1 end Separtment of Heelth mportant: If Item 27 any Injury or other trace.		20a. Method of Disposition  20b. Plece of Disposition (Name of cemetery, crematory or other place)	Date 2	Oc. Location -	City or To	wn, State
Pages nent of Indian or		1 Buriel 2 Cremation 3 Remove from State	12/23/2000	) Lar	idovei	, MD
Baltime permit. Pag Department Important: If any lojury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Stewart			2
m 82599		John 1. Slewar III 4001 Benning Rd	., N.E. Wa	ash., I	).C.	20019
Physician /Medical Examiner	ner	23a. Pas Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card ship, or heart failure. List only one cause on each line.  Immediate Ceuse (Final disease or condition resulting in death)  Due to (or as a consequence of):	Hemo	//	age (	Interval Between Onset end Deeth
. Box 68760, death certificate be executed ettending physician end of for use es the bunet-trensiti	Aedic	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last  Due to (or es a consequenca of):  Due to (or es e consequence of):				
P.O.	/ Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to		ntributs to	the cause of death
ev requir	Completed by		24a. Was ar perform		eva	re autopsy findings illable prior to apletion of cause death?
- F # &	Com		1 □ Ye	s No	1	Yes 2□ No
Ysician: The ysician: The ysician: The ysician: The ysician director, pag	Be	evaminer? \	eath (Check only of	9)		
of this of the side	tion: To	1   Yes 2   No	Home 5 Reside			)
Division I or Attending efter death. Director: After d in by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town	reet and Num! , State)	ber or Rura	l Route Number,
Division To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certiflier (Check only one)  Certiflier Physician: To the best of my knowledge, death occurred at the time, date and plate (Check only one)  Certiflier (Check only one)  Certiflier (Check only one)	curred et the time, de	ite end placa,	and due to	the cause(s)
To t withi Com	Σ	29b. Signature and titra of cartifier  29c. License number	18	kd. Date signe	a Month, i	Day Near)
(5)		30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)  James Catavenis, M.D. 3001 Hospital Dr., Ch		2078	35	
Sta	ate	31. Dete filed (Month, Day, Year)  32. Registrar's Signeture				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death De 4, 2000 DECEMBER SCAGGS 11:58 a.m. WILLIAM RICHARD 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death 5955 SCAGGS ROAD CALVERT OWINGS If Under 1 Year If Under 24 Hrs. Birthplace (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days Houra 11 M 2 F Yrs. 70 216 38 6270 Jan. 18, 1930 MD Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Owings MD Calvert. 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 5955 Scaggs Road 20736 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐ Yaa 2 No If Yas, Give 1 Yes 2 XNo Specify: white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grads completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) farmer agriculture 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surnama) George William Selby Scaggs Carrie Mabel Norton 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Bessie N. Scaggs (wife) same as 10 above 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 Burial 2 Cremation 3 Removal from State 12-18-00 Owings, MD Lower Marlboro UMC Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Ucar 22. Nama and Addrass of Facility Rausch Funeral Home, Owings, MD Do not enter the mode of dying, such as cardiac or raspiratory arrast, Approximate Interval Batween Onsat and Death Immediata Causa (Final disease or condition resulting in death) 2 weeks. 5 mall 2 Weeks cel Due to (or as e consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23h. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown obstructive Lung 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Diabetes Mellitus 1 Yas 2 No 1 ☐ Yas 2 ☐ No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

rel', or items 23a or 28s-f show Examiner nast be notified at

"naturel", or

el Hygiene. I other then "nature event, the Wed rel E

Pages 1 and 2 should be fill ment of Health and Mentel Hann; if frem 27 is marked oth tary or other traumatic even

Department of Important: If any Injury or page.

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filad within 72 hours efter

Baltimore, Maryland 21215-0020

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Director

Funeral

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Completed

Be

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical

25. Was casa referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 K Natural

2 Accident

3 ☐ Suicide

4 Homicide

28c. Injury at Work?

26. Placa of Death (Check only one)

Other: 4 Nursing Home 5 X Rasidence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Routa Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Data signed (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA

Placa of Injury - At home, farm, street, factory, office building, acc. (Specify)

29b. Signature and title of certifier eyou. c oura

5 Pending invastigation

6 Could not be detarmined

Hospital:

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

D 50653

GYAN - C. SURANA

1 Yas 2 No

12-15-2000

5851 - Deale Churchton 31. Date filed (Month, Day, Year)

32. Registrar's Signatura DEC 1 9 2000 D Gener

Rd. Deale

State Registrar

10

Division of Vital Records.

or Attending Physician:

Hospital

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After

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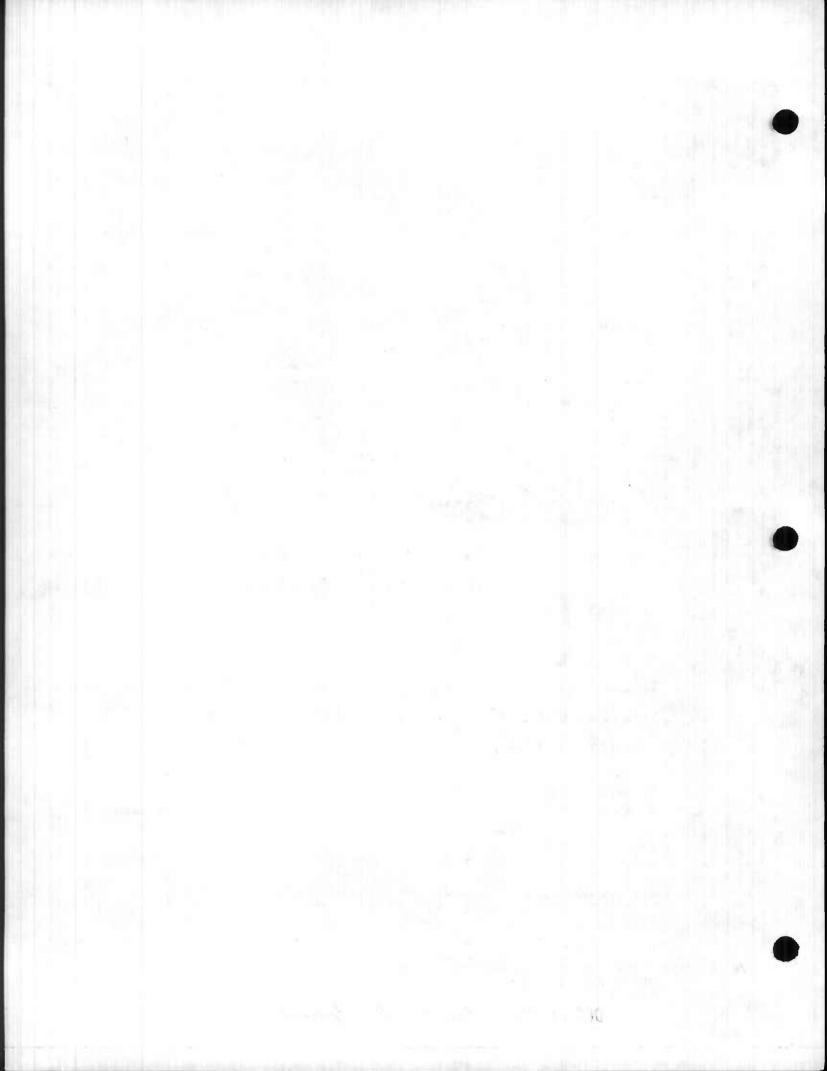
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Physici						Sappen:	fiold						Month	Day		Yaar	3. Time of I
/Medic Examin		40.	Facility Name	a Jau (If not institu		-				4	b. City, Tov	wn, or Lo	Decemb		, 20		9:34
Examin	ner			Woolse							hurch			70.		arfor	rd
Funeral		5. S	ocial Security		6. 8	Sex	7. Aga (In )	yrs. lest birthdey,		1 Year	If Under a	24 Hrs.	8. Date of Bir (Month, Da	th			ce (Stata or
Director		_	7-12-3			I□M 2⊠F		92 Yrs.	Months	Deys	Hours	Min.	Feb. 2	7, 1	908	Georg	yia Jia
show ad at		10e	. Stete	10b. Cou	inty		10c.	. City, Town or L	ocation							10	d. Insida City
28a-f shornorthing at	ctor	Ge	orgia	Glyr	nn			Brunswic	ck								↑ Vas
netural, or items 23a or 28a-f show dical Examiner must be notified at	Funeral Director	10e	Street and N	umber					10f. Zlp	Code				10g. Citiz	zan of Wh	hat Countr	y?
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or Items miner m	une	1	Meritel Stetus		411.4	Armed I		in U,S. 13.	Was Daced If Yes, spec	dant of Hi cify Cube	spenic Orig n, Maxicen	gin? (Sp , Puarto	ecify Yas or No Ricen, atc.)	- 1		<ul> <li>Amarice</li> <li>Whita, at</li> </ul>	
0,00	by F	1	l □ Navar Ma: 3☑ Widowed			if Yes, C	22 No Sive		1 ☐ Yas	2 <b>X</b> ) No	Specify:				Specify:	TATI	nite
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Is m		198	. Informant's f	Neme/Ralati	onship (	Type, Print)							al Route Numb				
of Health Item 27 I			David C Mathod of Di		ge /	Son i		3103 b. Place of Disp			Drive	e, C	hurchvi Data				
0		200	Burial 2	Cramatic		Ramovel from	n Stata	cematary, cra	metory or o	ther place		1				city or Tow	
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death IARION December 15 2000 0710 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 5. Social Security Number Social Security Number Usual Residence of Decedent If Under 1 Yeer | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1□M 20F Months Days Hours Yrs. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits HEBRON 1 Yes 2 No WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? OCEANGATEWAY 21830 ().S.A. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FOOD SERVICE DELI MANAGER VEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) OLIVER MILLS LOUISE INSLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) POBERT J. TAYLOR (HUSBAND.) 27220 OCEANGHTEWAY HEBRON, MD 21830 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 12/18/2000 HEBRON, MID HEBROW CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WESSICK FUNERAL HOME PO BOX 61 BYALVE, mD 21814 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, App. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) severe COPD Due to (or as a consequenca of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or as a consequence of) AUVIL Stendsin Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ostopasty OVA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2/2 No 1 ☐ Yes 20 No 25. Was cese referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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Examiner

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**Examiner** 

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Medical Certification:

29a. Certifier

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

State Registrar Naksaw , nd

29b. Signature and title of certifier

and manner stated 29c. License number

247044

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

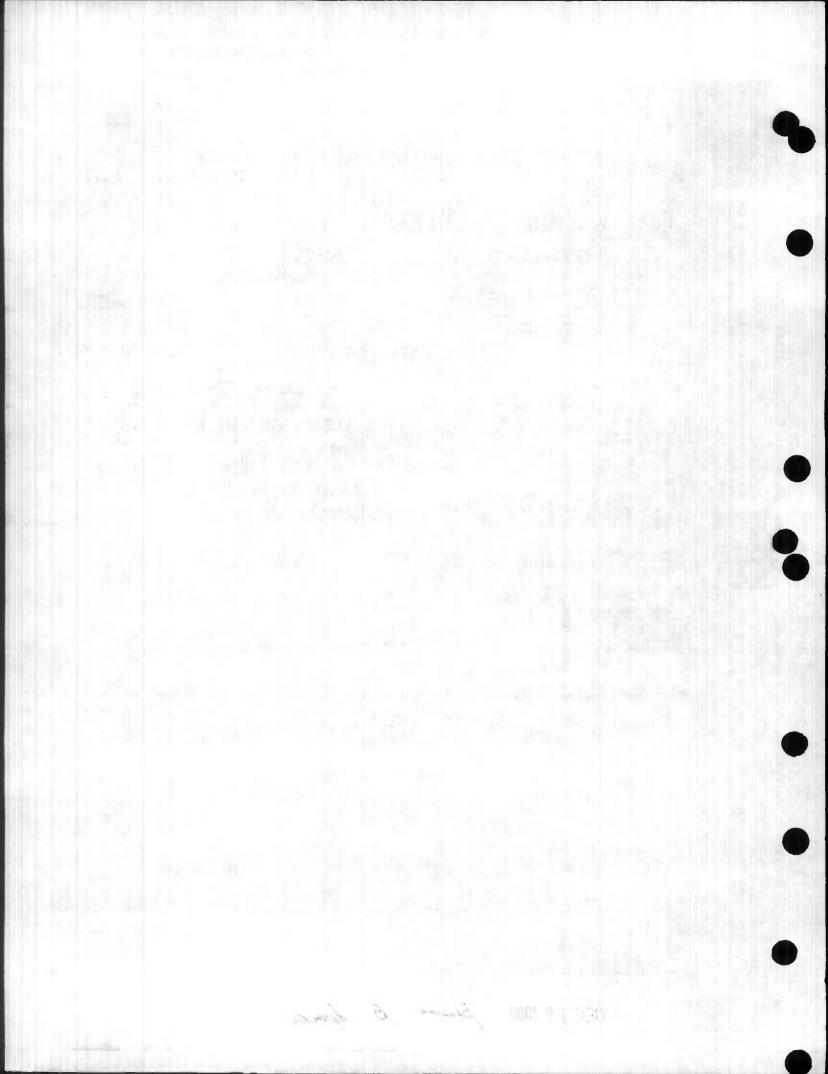
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 12/16/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. NATESAN MD ING PINE BLUFF RUAD

MD 21801

1 9 2000 Registrary Signature 31. Date filed (Month, Day, Year)



Please Type or Print In Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 42529 Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 4b. City. Jown. or Location of Death Was Carrot Peeth KENNETH EUGENE TYLER, SR 4e Fscility Neme (If not institution, give street end number)
PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 55 Yrs. 213-44-0503 JULY 21, 1945 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 ☐ Yes 2 ☐ No MARYLAND SOMERSET PRINCESS ANNE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 31746 PEGGY NECK RD 21853 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Bjack, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1X Yes 2 No1965-72 If Yes, Give 1 ☐ Never Merried 2 ☑ Married 1 Yes 2 No Specify: Specify: WHITE-AMERICAN INDIAN n Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGER MANUFACTURING CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) VINCENT LEE TYLER VIRGINIA MARSH 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 31746 PEGGY NECK RD PRINCESS ANNE, MD 21853 MARION SUE TYLER - WIFE 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 I Cremetion 3 ☐ Removel from State 12/18/00 CAMBRIDGE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) CAMBRIDGE CREMATORY 21. Signeture of Funeral Service Licenses 22. Name end Address ot Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 BOUNDS FUNERAL HOME, INC.

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teilure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final 24 hours astroinkstrul disease or condition resulting in deeth) Due to (or es e consequence of): Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence ot): Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Place ot Death (Check only one) Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Injury 1 Maturel 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide

Examiner 68760 Box ( P.O. Records, Division of Vital

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8 l or Attending Physician: after death. To the Hospital of within 24 hours at To the Funeral D completely filled I

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Registrar

29b. Signature and title of certifier CQ ( DIME 29c. License number H50 49)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated
2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) end menner steted.

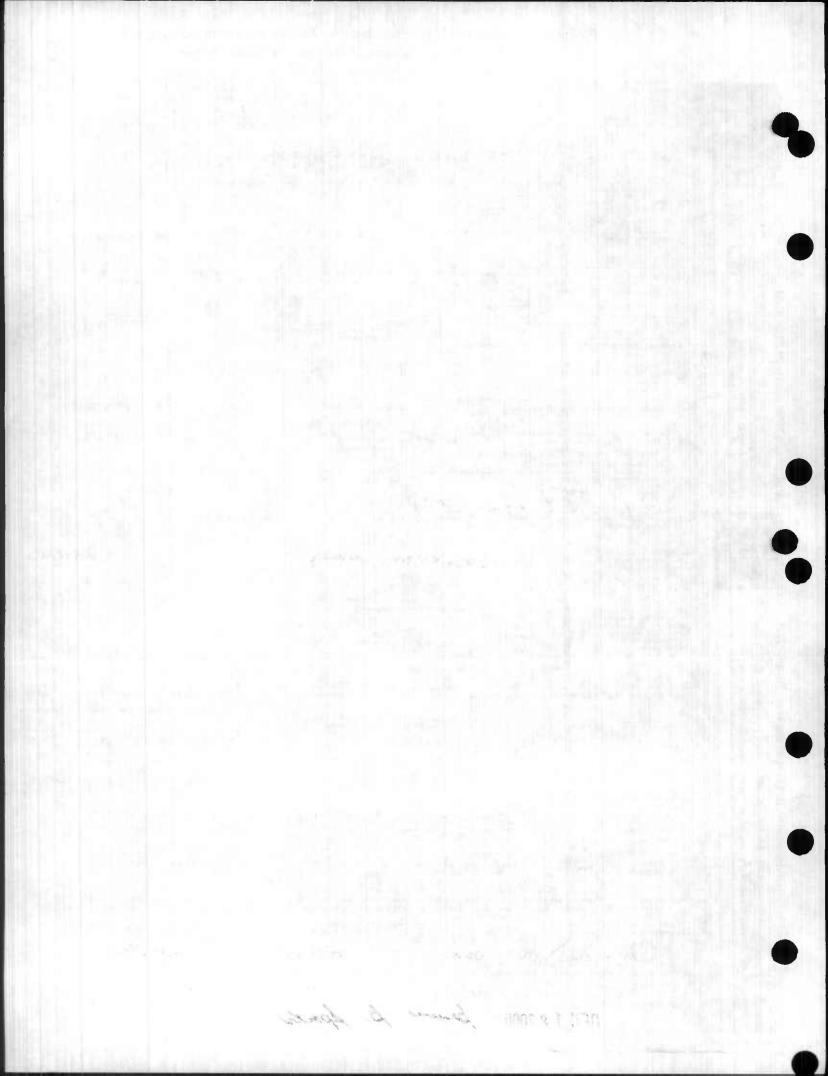
29d. Date signed (Month, Dey, Year) 12/16/00

SAlisbury Mcl

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

NFC 1 x 2000 ▶

Chais Souder Do 106 Milford St Suite 201 31. Dete tiled (Month, Dey, Year) 32. Registrer's Signeture



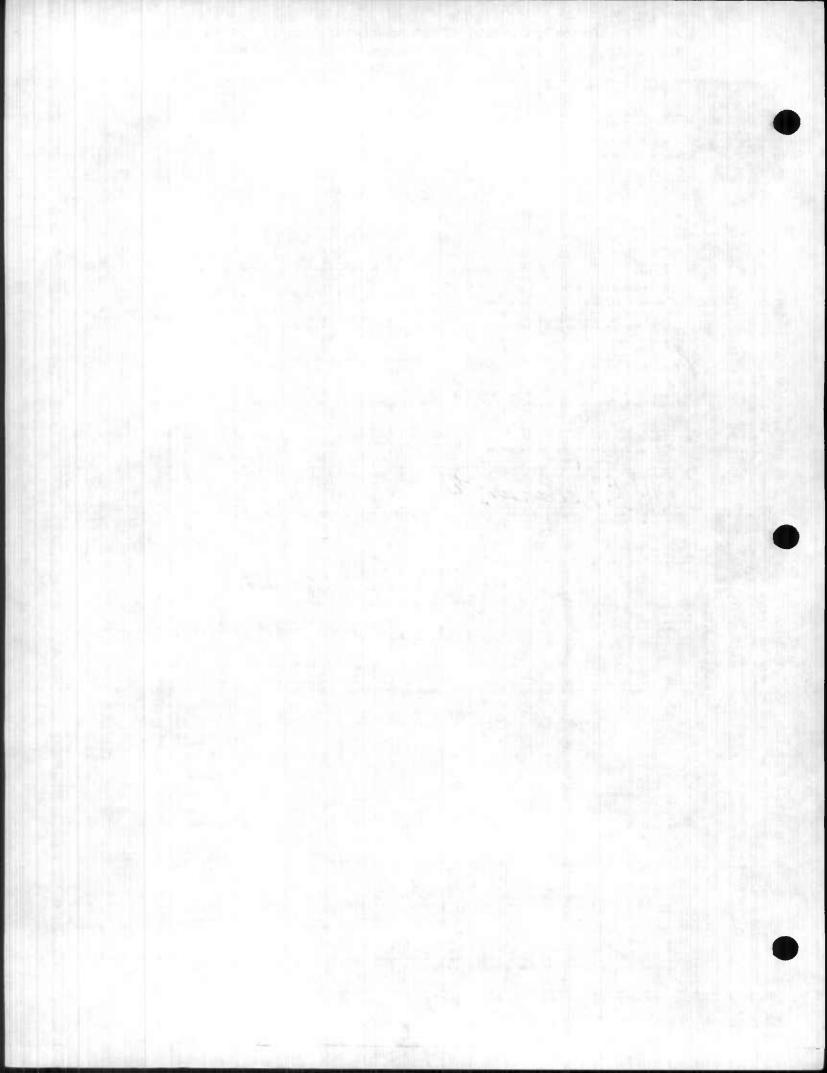
TAYIOR, Carolyn 12/17/00 4:45 pm date / time of death.

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

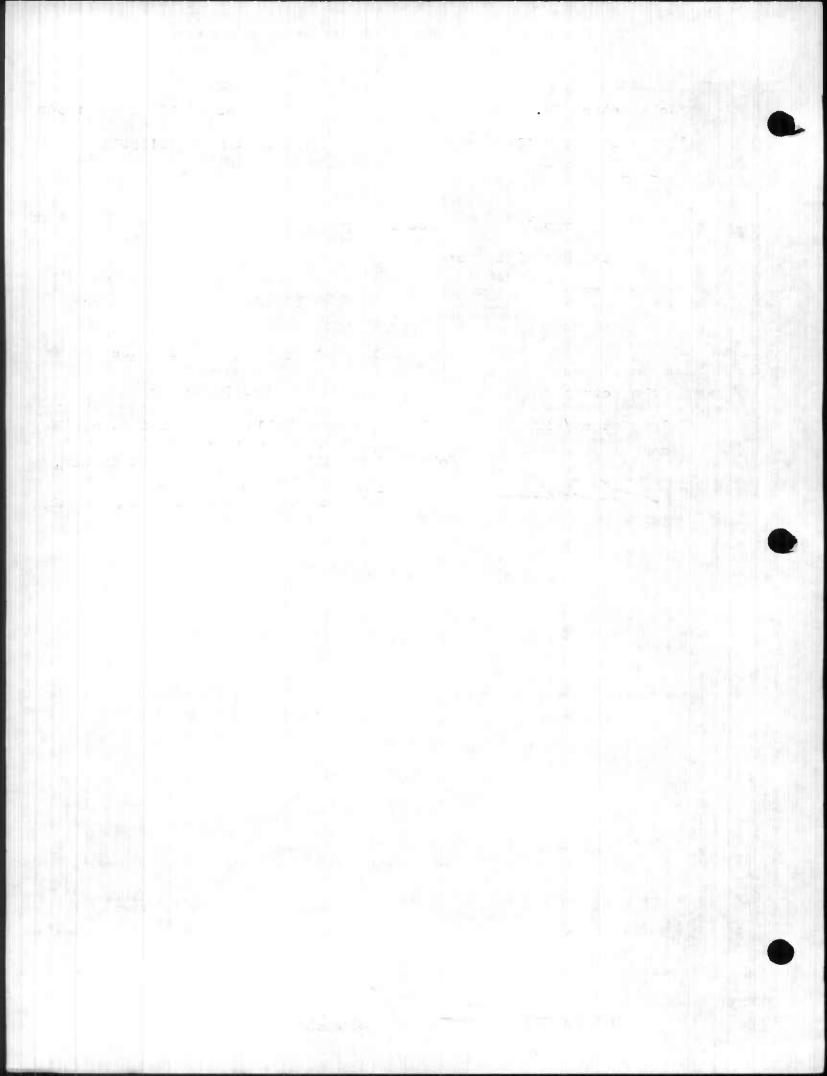
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	Certificate of Death	100	Reg. No.	0 42000
<b>D</b> I 12 <sup>2</sup> 1	Decedent's Nama (First, Middla, Last)	2, Data of De Month		3. Time of Deeth
Physician /Medical	CAROLYN VOGT TAYLOR	DECEMB	ER 17 20	000 4:45 PM
Examiner		wn, or Location of Deat		
	DRIGHTON OLD	IESDA	MONTG	
Funeral Director	5. Social Security Number 6. Sex 1 Months 1 Mont	24 Hrs. 8. Data of Bi (Month, Di MAR 11		Birthplaca (Steta or Foraign Country)  WASHINGTON D.C
,	Usual Residence of Decedenf  10a, Stata 10b, County 10c, City, Town or Location			10d. Inside City Limits
or 28a-f show a notified at Director				1 ☐ Yas XX No
Director	MD TALBOT EASTON		10g. Citizen of W	
2 5	10e. Street and Number			tial Country?
era		inin? (Specify Vec or N	USA 14 Bace	- Amarican Indian,
by Funeral Director	Armed Forcas? If Yas, specify Cuban, Maxicer  1 Never Married 2 Married 1 Yas 2 No If Yas, specify Cuban, Maxicer  1 Yas 2 No Specify:  3 No Specify:		Black	whita, etc.
a pet	15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during mos	t of working	16b. Kind of Bu	siness/Industry
rt, pre Medical	(Specify only highast grada completed) (Giva kind of work dona during mos life. DO NOT usa ratired)  Etementary/Secondary (0-12) Collega (1-4or 5+)			247
5	12 4 HOMEMAKER		OWN HO	
Be	17. Famar's Nama (First, Middla, Last)	ar's Nama (First, Middle		a)
0	FREDERICK L. VOGI	ANOR SCHULZ		
any injury or other traumant avant, the space.  To Be Comp	19e. Informant's Name/Ralationship (Type, Print)  ROBERT F. TAYLOR  19b. Meiling Addrass (Streat and Number 6117 RAMSGATE RD.,			
Ď	20a. Mathod of Disposition  20b. Place of Disposition (Nama of camatary, crematory or other place)	Data	20c. Location -	City or Town, Stata
	1 Surial 2 □ Cramation 3 □ Ramoval from State 4 □ Donation 5 □ Other (Specify)  OXFORD CEMETERY	12-21-00	OXFORD,	MD
	21. Signature 4 Funarat Sarvice Licensea 22. Nama and Addrass of Facility	ty		
eny ir	FELLOWS, HELFEN 200 S. HARRISON	ST EASTON.	NAM FUNER	AL HOME PA
	23a. Pant. Intar the disaasa, or complications that caused the death. Do not anter the mode of dying, such as shock, in heart failure. List only one cause on each line.			Approximata Intarval Batwaan
cian				Onset and Death
ical	Immediata Causa (Finat diseasa or condition Brance Pneumant	4		days
iner	Immediata Causa (Finat diseasa or condition raaulting in death)  Branca Pneumant  Dua to (or as a consequence of):  Cerebro Vasculan Acci	1		
je	Cerebro Vasculan Acci	least		meeks
edical Examiner	0.			
Ä	Sequentially list conditions, if any, leading to immadiata ceuse. Entar Undarrying Cause (Disease or Injury c.			
Ca	that initiated events			
· <	rasulting in death) Last			
by Physician/	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part	I. 23b. Did	I tobacco use cor	tribute to the cause of death?
hy:	Cancer I the Convses	10	Yes 2 No	3 Probably 4 DUnknown
be detached for use by Physician/A	Canal of the stronger			
should be del			s en autopsy ormad?	24b. Were eutopsy findings available prior to
2 sh				completion of cause of death?
director, page 2 should		10	Yas 2 No	1 ☐ Yas 2 ☐ No
e C	25. Was cese rafarred to medical 26. Place	a of Death (Check only	ona)	
0	axaminar?   Hospital: Other:	ursing Homa 5 ☐ Ras		ar (Spacify)
	27. Mannar of Death 28a, Dete of Injury 28b. Tima of 28c. Injury at		how injury occurr	
e fun	1 Hatural 5 Pending (Month, Dey Year) Injury Work? 2 Accident invastigation M 1 Yas 2	No		
A P	3 Suicida 6 Could not be determined 28a. Plece of Injury - At home, farm, straet, factory, office	28f. Location	(Straat and Numb	er or Rural Routa Number,
d in	4 Homicide building, afc. (Specify)	City of 10	own, Stata)	
completely filled in by the lunare Medical Certification:	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, daeth occurred et the time, dete er (Check only one)  2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, dae and manner stated.			
To the Funeral Director completely filled in by the	29b. Signature and title and title 29c. License number		29d. Dafe signed	(Month, Qay, Year)
ō	1 / for 1 133.	317	121	19/2000
	1) 3).			19/2000 mg Chase me
	30. Name and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print)	concin d	Ine ()	a Char ha
	31. Data filed (Month, Dey, Year) Registrar's Signature	-0.3	July Ch	any crosse me
State Registrar	DEC 2 0 2000			
Registrar	DEU & U LUUU / . POORMA!			



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		State of Maryland		ment of F icate of			giene () (Reg. No.	0 42531	
	1. Decedent's Nama (First, Middle, L	ast)				2. Data of De Month		3. Tima of Death	
hysician /Medical	John Totura J	r.				Dec	- /	2000 7:25am	
xaminer	4a Facility Name (If not Institution, g	ive street end number)			4b. City, Town, or Lo	ocation of Death	4c. County of	of Death	
	1323 Bachmans	Valley Road			Westmin	ster	Carr	coll	
neral		Sex 7. Age (In yrs. In	M	Undar 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Dete of Bird (Month, De	h y, Year)	Birthplace (State or Foreign Country)	Ī
ctor	213-28-2698	XDXM 2□F 8(	O Yrs.				1920	PA	
	Usual Residence of Decedent	10. 04.	. Town or Locati					104 Inside City I Inside	_
-	10a. Stete 10b. County	Toc. City	, TOWN OF LOCAL	Ori				10d. Insida City Limits 1 ☐ Yes 杂□No	
oto	MD Carr	oll We	estmins						
Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	het Country?	
	1323 Bachmans			2115			USA		
Funeral	11. Marital Status	12. Was Decedent Evar in U.S Armed Forces?	S. 13. Wes	Decedent of I es, specify Cub	Hispanic Origin? (Sp an, Mexican, Puarto	ecity Yas or No Rican, etc.)		- American Indien, c, White, etc.	
	1 Nevar Married XX Merried	If Yes, Give	10	Yes 20 No	Specify:		Specify:	White	
d by	3 Widowed 4 Divorced	Year or Dates:				8			Ų
Completed	15. Decedent's (Specify only highest g		16a. Decedent	's Usuel Occup d of work done	pation during most of work id)	ing	16b. Kind of Bus		
효	Elementery/Secondary (0-12)	College (1-4or 5+)		lf Emp				ock Buyer	
	17. Father's Nama (First, Middla, Las	3	ne_	rr rmp	18. Mother's Nam	a (First Middle			4
Be	The second secon	,,			0 00				
10	John Totura  19a. Informant's Name/Relationship	(T	101 11-11-11	11 (01	Suzann			State Zin Code) O = = = 0	-
		, , ,						Stete, Zip Code) 21158	
	Helen Totura/w 20a. Method of Disposition		ece of Disposition		ns valle	Date	Westmin	Sity of Town State	-
	12 DBuriel 2 ☐ Cremetion 3	□Removal from State C6	emetary, cremeto	ory or other ple	(ce) 12	2/18/2	000	City or Town, State	
	4 Donation 5 Other (Spec	,,	hn Luth			n	West	minster, MD	
88	21. Signature of Funeral Sarvice Lic	ensu	Pri	tts F	ess of Fecility uneral H	ome ar	d Chap	el	
	1/1/1	/	412	Wash	ington R	d West	minste	r, MD 21157	
	23a. Part1. Enter tha disaase, or co shock, or heart failure. List on	mplications that caused the deeth	. Do not enter th	ne mode of dyi	ing, such as cardiac	or respiratory a	rrest,	Approximate Interval Between	
n		,						Onset and Deeth	
1	Immediate Ceuse (Final disease or condition	Gast	ric e	arcin	to Juny de			1 40.	
	resulting in deeth)		r es e consequer						
ine.									
Examine	Sequentially list conditions,	Due to (or	as a consequen	ice of):					
calE	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	c							
₹	that initiated events resulting in death) Last	Dua to (or	as a consequen	ce of):					
Physiclan/Me		l d							7
lan									Ī
/sic	Pert II. Other eignificant conditions	contributing to death but not resu	ılting in the unde	rlying cause gi	iven in Part I.	23b. Did	tobacco uae con	tribute to the cause of death?	
	Prostat	he carcino	in an			10	Yee 2□ No	3 □ Probably 4 ☑ Unknown	
by			-4						-
Completed							an eutopsy rmed?	24b. Were autopsy findings available prior to	
ple		NEW YORK OF SAME						completion of cause of deeth?	
TO.						10	Yes 2 No	1 ☐ Yes 2 ☐ No	ı
Be	25. Wes case referred to medical examinar?				26. Place of Deal	h (Check only	one)		
To	1 Yes 2 No	Hospitel: 1 Inpatient 2 I	ER/Outpatient	3 DOA O	her: 4 Nursing Ho	ome 5 Resi	dence 6 Othe	ar (Specify)	
	27. Manner of Death 1 ☑ Netural 5 ☐ Pending	28e. Date of injury (Month, Dey Year)	28b. Time of Injury	28c. Inju	ury at ork?	28d. Describe	how injury occurre	ed	
atic	2 Accident investigati	on			Yes 2□No				
tific	3 ☐ Suicide 6 ☐ Could not determine	be d 28e. Plece of Injury - At ho building, etc. (Specify	me, ferm, streat,	fectory, office		28f. Location (		er or Rurel Route Number,	
Certification:		Sunding, die. (Opacity	,			2., 0., 0	, 5.5.5/		
edical		thysician: To the best of my known iminer: On the basis of examinet and manner stated.							
Medical Certification:	29b. Signature and title of certifier			29c. Licen	se number		29d. Data signed	(Month, Dey, Year)	-
	11-01	+ 1 0			552		12/1.		
	Brown &	aury, M.V.	\				-		
	30. Neme and address of person wh				P. 1.				
	31. Date filed (Month, Dev, Year)	t z m.D. 555		Ter.	IT. We.	TM: 437	my md.		
State	DEO 1 0	32. Registrer's Signet		1					
gistrar	DEC 1 X	/		MAR	W. /				



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Date of Death Month Day Year December 6, 2000 20:22 Sallie. Mae 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George Southern Maryland Hospital Clinton, MD If Under 1 Yeer | If Under 24 Hrs. 8. Data of Birth Month Day Xead April 28,1938 Florence, S.C. 5. Social Security Number 7. Aga (In yrs. last birthday) Days Hours 10 M 2 F Months 62 251-58-1511 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits No Yas 2 No Maryland Prince George Oxon Hill 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 2204 Allison Avenue #204 20745 United States 12. Was Decedant Evar in U,S. Armad Forcas? 1 to Yas 2 □ No If Yes, Give 13. Was Decedant of Hispenic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexicen, Puarto Rican, etc.) Race - American Indien, Bleck, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2XXNo Specify: Specify: Black 3XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Giva kind of work done during most of working lifa. DO NOT use retired) Elemantary/Secondary (0-12) College (1-4or 5+) Mail Sorter Private 12th 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) George Green Nellie Smalls 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 1629 "R" Street SE Wash DC 20020 Mary G. Ford / Sister 20b. Place of Disposition (Name of cematary, crametory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removel from State Arlington National 12/14/2000 Arlington VA 4 Donation 5 Other (Specify) 22. Name and Addrass of Facility Robert G. Mason Funeral Home 21. Stonature of Euneral Sarvice Licent 1661 Good Hope Rd SE, WashDC 20020 23 Pert]. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset end Death Immediata Cause (Final disaasa or condition rasulting in death) Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner** 

been signed by I should be detact

page 2 s

or Attending Physician:

To the Hospital or attentions within 24 hours after death.

To the Funeral Director: Aft

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Completed

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Certification:

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Physician

/Medical

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**Funeral** 

Director

ed other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at

the Manyland

72 hours after

Hygiena.

permit. Pages 1 and 2 should be file Department of Health and Mentel Hy, Important: If fem 27 is marked othe any injury or other traumatic event, phose.

Physician/Medical Examiner ed by the attending physician end detached for use es the burial-transit Sequentially list conditions, if any, leading to immadiate ceuse. Entar Underlying Cause (Disaase or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. CEREBROVASCULAR OSTEOMYELITIS 25. Was casa rafarred to medicel

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 Yas 2 No 24b. Were eutopsy findings available prior to completion of cause of death?

26. Placa of Death (Check only ona)

1 Yas 2 No

1 Yas 2 1	lo	1 X Inpa	atiant 2	ER/Outpatient	3	DOA OTIAL.	■ Nursing	Homa 5 ☐ Rasidence 6 ☐ Othar (Specify)
27. Mannar of Death  1 ⊠Netural  2 □ Accident	5 Panding Invastigetion 6 Could not b	1	njury Day Year)	28b. Tima of Injury	М	28c. Injury et Work? 1 \( \text{Yas}	2 🗆 No	28d. Dascribe how injury occurred
3 Suicide 4 Homicide		e 28a. Place of building,	Injury - At h etc. (Specil	ome, ferm, stree	t, fact	tory, office	28f. Location (Street and Number or Rural Routa Number City or Town, Stata)	

29a Certifier

1 Certifying Physician: To the best of my knowledge, daeth occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

29b. Signatura and titla of certil MD

30. Name and addrass of payson who completed ceusa of death (Item 23a) (Type, Print)

3885

307

29d. Data signed (Month, Day, Year) 2000

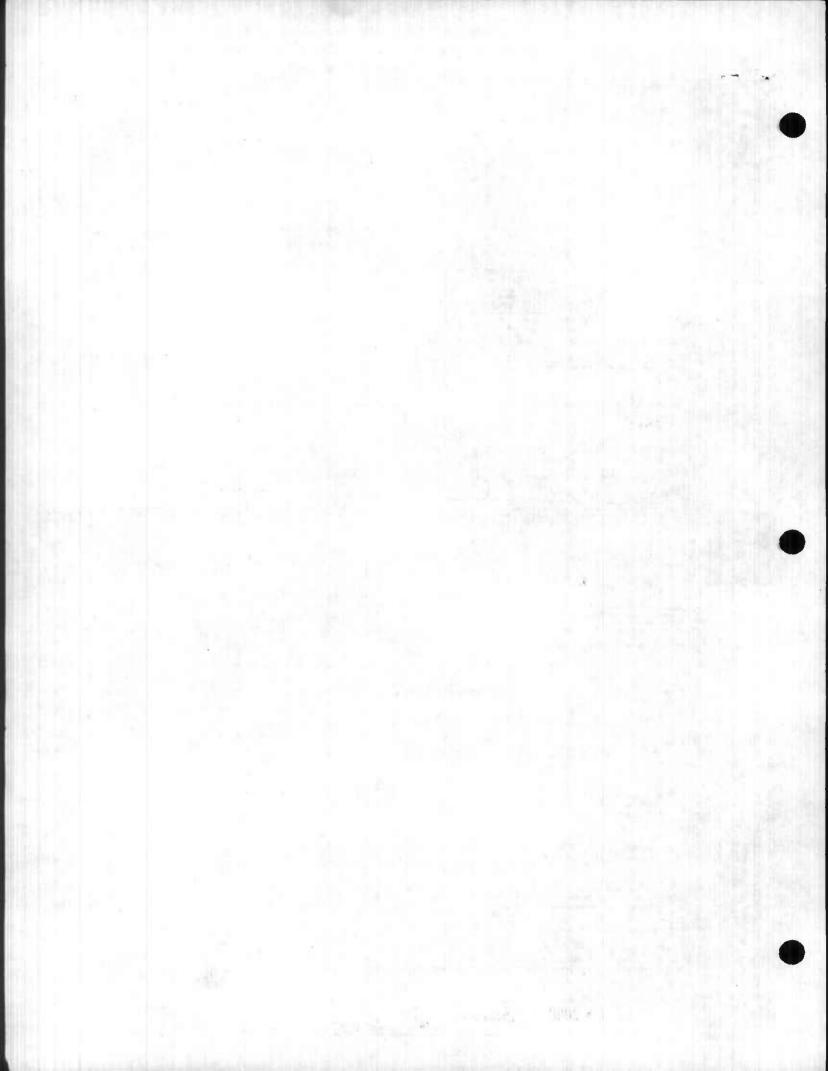
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7501 32. Registrar's Signatura

31. Data filed (Month, Day, Year) DEC 18 2000

SURRATIS

Registrar



## Please Type or Print in Biack indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Thomas Lerov 14, 2000 6:03 P.M. December /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health of Southern Maryland Prince Georges Clinton If Under 24 Hrs. 8. Date of Birth Hours | Min. | Month, Day, Year) 944 9. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 10 M 2□ F Months Yrs. 56 577-58-2777 Director November 26, Washington, D.C. **Usual Residence of Decedent** the Menylend 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show "natural", or itema 23a or 28a-f ehov adical Examiner must be notified at TXXYes 2 □ No Director Washington District of Columbia 10e. Street and Number 10f. Zip Code 10c. Citizen of Whal Country? Apt. 303 3800 New Hampshire Avenue, N. W. 20011 United States Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ② No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, be filed within 72 hours efter de ital Hygiene. Id other than "natural", or fram event, the Hedical Emmont Bleck, White, etc. 1 Never Married 2 Married 21215-0020 1 Yes XXNo Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygles. Important: if Item 27 is marked other th any hijury or other treumatic event, the page. 9th grade Housekeeper Hotels Baitimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 Evelyn Fitzgerald .James Thomas, Sr. Ethel 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20002 Dorothy Thomas (sister) 1107 Holbrook Terrace, N.E.; Apt. 3; Washington, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 22, 2000 20a. Method ol Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, Maryland 21. Signature of Funeral Service Liganse 22. Name and Address of Facility R. N. Horton Company Morticians, Inc. Konanick 600 Kennedy Street, N. W.; Washington, D. C.2001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death >Physician Immediate Cause (Final disease or condition resulting in death) /Medical BACTEREMIA Examiner Due to (or as a consequence of). Physician/Medical Examiner ACQUIRED IMMUNE - DEFICIENCY SYNDROME nding physicien end use as the burlet-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Due to (or as a consequence of) P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by the page 2 should be deteched 1 Yes 2 No 3 Probably 4 Unknown ENTEROCOCEAL LACTEREMY of Vital Records, ٥ 24b. Were autopsy lindings eveilable prior to completion of cause of death? Be Completed CORENLEY DECERY DISEASE 24a. Was an eutopsy performed? INFECTED SACKAR DECYBITUS WLEEPS 1 Yes 2 No 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 1 Netural 5 Pending efter deeth. Director: Aft d in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours of To the Funerel D completely filled I 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steled. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -Wya-Cool D0015513 (MD) MO December |5, 2000 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Lucio S. Villa-Real, M.D.; 10 St. Patrick Drive, Suite 502; Waldorf, Maryland 20603

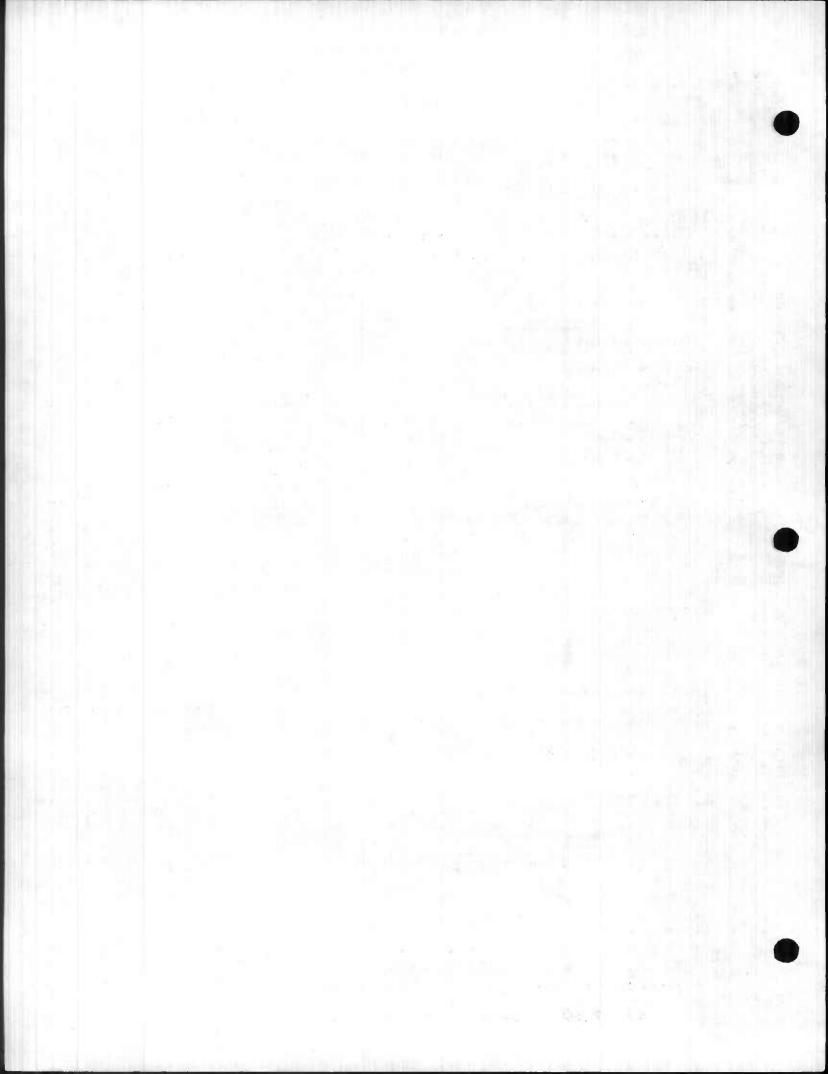
DHMH 16 Rev 6/95

Registrar

31. Date liled (Month, Day, Year)

DEC 18 2000

Registrar's Signature



31. Data filed (Month, Day, Year) State DEC 2 1 2000 Registrar

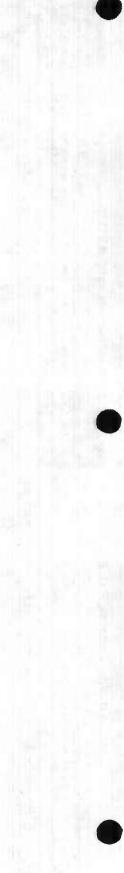
ROINTAN FARAHIFAR

9801 Georgia Are Suit 3-35 SILVER SPRING, MD 20902 32. Registrar's Signatura

M.D.

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

G. Goods



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

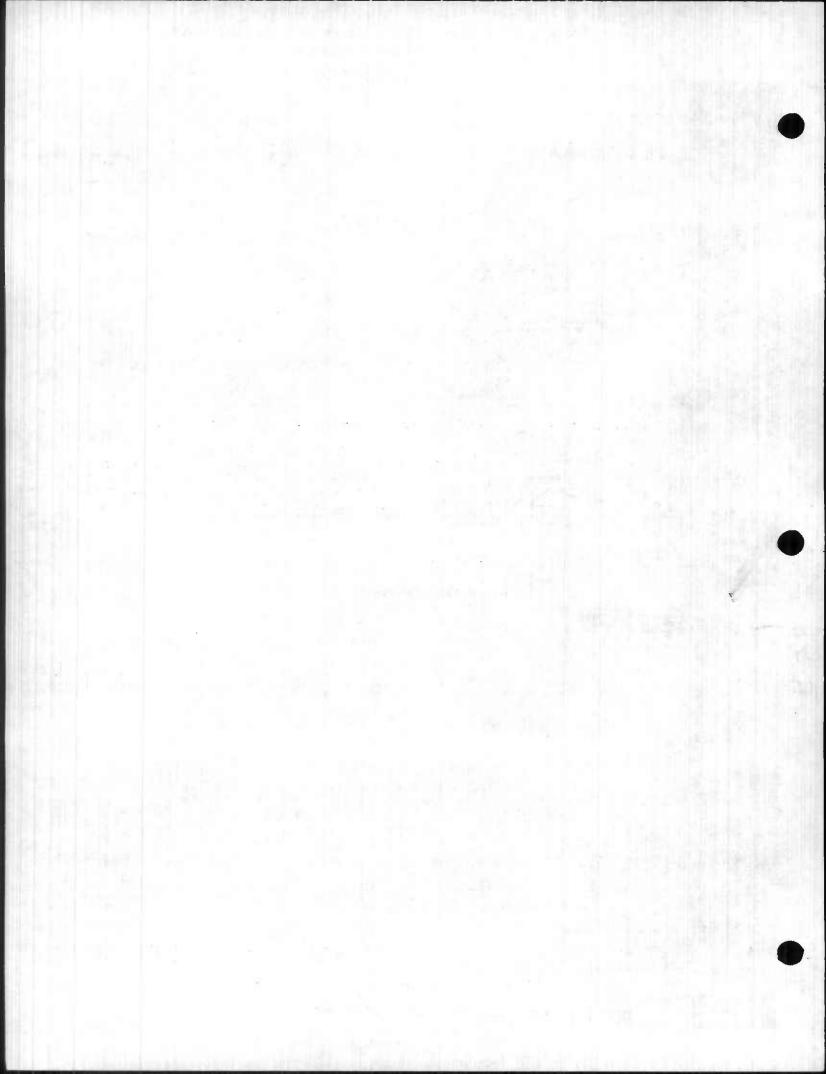
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** December 10, 2000 11:13AM Lucy A. Thoms /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Bethesda Carriage Hill of Bethesda Montgomery If Under 1 Yaar If Undar 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 F 97 Director June 11, 1903 New York 060-03-6612 Usuel Rasidence of Decedant the Maryland 10a. Stata 10d. Inside City Limits 10b. County 10c. City, Town or Location mast be notified at 1 Yes 2 □ No Director Washington, D.C. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4000 Cathedral Avenue, N.W., #501-B United States death Funeral 20016 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Yeer or Dates: r than "natural", or items the Medical Examiner ma 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: by 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede complated) (Give kind of work done during most of working life. DO NOT use retired) filed within Elementery/Secondery (0-12) College (1-4or 5+) Hyglene. Telephone Company 12 Supervisor 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumema) . Pages 1 and 2 should be fill ment of Health end Mental Heart: If them 27 is marked oth lury or other traumatic sven Be Filomena Grieco Frank Abarno 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20016 19e. Informent's Neme/Reletionship (Type, Print) 4000 Cathedral Avenue, N.W., #501-B, Washington, DC David W. Kingsbury, M.D./Nephew Baltimore, 20b. Plece of Disposition (Name of cematary, crematory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete Dec 11 4 Conetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2000 Bethesda, Maryland Pumphrey Funeral Home/ 21. Signature of Funerel Service Licental 22. Name and Address of Facility Robert A. Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

M00803 Bethesda, Maryland 20814-3501

23e. Pert1. Enter the disaese, or complications that bused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest,

Approximete Approximete Intervel Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Respiratory Failure Examine Due to (or es a consequence of) Examiner Aspiration Pneumonia Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that Initieted events resulting in death) Last attending physician end for use as the burial-tran Due to (or es e consequence of): Dementia Physician/Medical Due to (or as a consaquanca of): 88 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b by Division of Vital Records. 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed page 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No this 28a. Dete of Injury (Month, Day Year) funerai 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Netural 5 Pending Invastigation death. 1 Yas 2 No 2 Accident or Attend after death Director: 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) lilled in by 4 Homicide Hospital 24 hours till Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) end menner steted. 29e. Certifiar To the Hosp within 24 hor To the Fune completely fi edical 29b. Signatura and titla of certifier 29c. Licensa number 29d. Data signad (Month, Day, Year) U Sioseny Stronus 10 December 11, 2000 D47330 30. Nema and address of person who completed cause of deeth (Item 23a) (Type, Print) 50 West Edmonston Drive, #207, Rockville, Maryland 20852 M.D. Thomas V. Joseph, 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State DEC 1 2 2000 Registra



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) **Physician** 1300 December 10, 2000 Sara Elizabeth Travers /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 34 Pritchard Ave. Apt. A-1 Aberdeen Harford If Undar 24 Hrs. If Under 1 Yaar Birthplace (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Deys Hours 1 M 2 F Yrs May 30, 1906 94 Maryland Director 218-32-2751 Usual Rasidence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 XYas 2 No MD Harford Aberdeen Director 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 528 Bonnie Drive 21001 U.S.A. Funeral 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11 Marital Status 1 ☐ Yas 2 No If Yas, Giva 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 200 No Specify: Specify: White p 3℃ Widowed 4 Divorced Yaar or Dates Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education
(Specify only highast grada complated) 16b Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Homemaker In home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be Pages 1 end 2 should be inent of Health end Mental Int: If item 27 is marked or Charles Walter Armour Georgiana Harrington 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Steta, Zip Coda) Department of Health en Important: If Itam 27 is: any injury or other trau Michael R. Travers (Son) 528 Bonnie Drive, Aberdeen, Maryland 21001 20b. Place of Disposition (Nema of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition Data 1 Burial 2 Cremetion 3 Removal from Stata 12/13/00 Aberdeen, Maryland Baker Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Addrass of Facility
Tarring-Cargo Funeral Home, P.A. 21. Signature of Fuperal Service Lici Aberdeen, Maryland 21001-3399 6 argo, ganer 23a. Parf1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Death **Physician** Immediata Cause (Finel disaasa or condition resulting in death) /Medical DAYS MYOCARDIAL INFARCTION Examiner Dua to (or as a consequance of): Examine YEARS DISEASE CORONARY ARTERY Sequentially list conditions, if any, leading to Immadiata ceusa. Enter Undarfying Cause (Disaase or injury that initialed events rasulting In death) Last Dua to (or as a consequance of): Years Hypertension
Due to (or as a consequence of): Physician/Medical YEARS FIBRILLATION ATRIAL 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown HYPOTHYROLDISM þ 24b. Wara autopsy findings aveilable prior to complation of ceusa of death? 24a. Was an autopsy performed? Completed MELLITUS NOW INSULIN DIABETES 1 □ Yas 2 No 1 Yas 2 No CHRONIC RENAL INSUPFICIENCY Division of Vital 25. Was cesa rafarred to medicel examiner? Be 26. Placa of Deeth (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 0 this 27. Manner of Death 1 Matural 28a. Data of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Panding death. 1 ☐ Yas 2 ☐ No invastigation Director: A 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, streat, fectory, office building, etc. (Specify) 4 Homicide or / Hospital of 24 hours a Funeral D Medical 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner es stated 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. (Check only one) Within 2 To the 29d. Date signed (Month, Day, Year) 29c. Licansa number 29b. Signeture end title of certifier December 11, 2000 MU D0047711 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) NORTH EAST MARYLAND DAVID GAR-BL 3 MAULDIN AVENUE 2. Ragistrar's Signeture Registrar

Company Common our

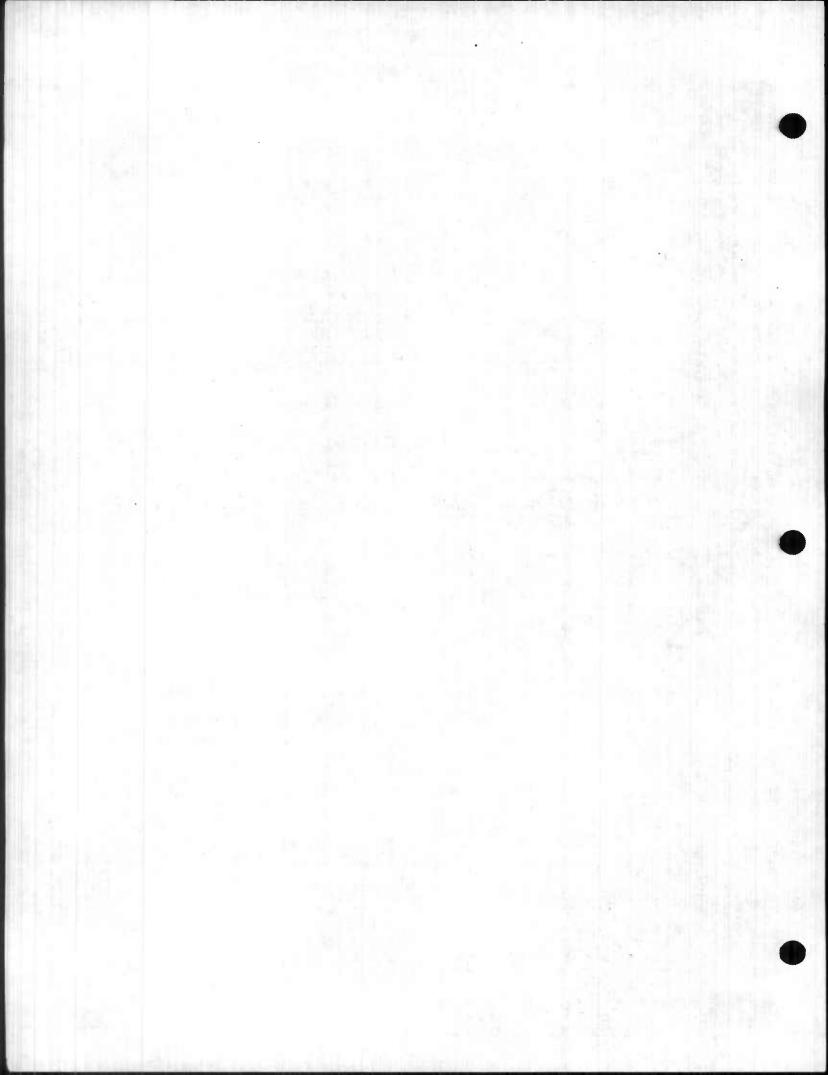
00-7414-047 FRED VAUGHN

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ter de	5	11. Meritel Stetus	ied 2□ Married	Armed Fo	orces?	7,5.	Yes, speci	fy Cub	an, Mexican, Puer	to Rican, etc.)	14.	Bleck, White,	
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1215-0036 within 72 hours after deeth with the Menyland and and a contract of the contract of			15. Decedent's Ed	ducation		16a. Deced	lent's Usuel	Occup	pation		16b. Kind	of Business/Ir	ndustry
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nd 2	Be	17. Father's Name	(First, Middle, Last,	)					18. Mother's Ne	me (First, Mido	lle, Maiden Su	mame)	
Va Went	9 OL	George W	Vashingto	n Vaugh	n					Ann Fe			
Maryland 2 nd 2 should be filed lith and Mental Hygi	5		ame/Reletionship (	Type, Pnnt)					t and Number or A				
or 1 end 2	100	Donald P.		(son)	l-a				Rd., Po		1		
Peges 1	8	20a. Method of Dis	position □Cremetion 3 □	Removal from	State	Plece of Dispo cemetery, cren	netory or oti	her ple		Date		ion - City or T	
timen timen	lan		5 ☐ Other (Specif		Betl					12/28/0	Pocon	ke City	, Maryland
Baltimore, Maryland 21215-0036  permit. Peges 1 end 2 should be filed within 72 hours at Department of Hearly and Mental Hyghene.	eny injury or o	21. Signeture of Fu	nerel Service Licer	1500		HO HO	. Neme end	Addre V M	ess of Fecility elson Fu	neral H	ome, P	Α.	
- 403		Much	nel Al	Jean	mulla.	9 10	3 Lin	den	Ave. P	ocomoke	City,		
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DIVISION Of VITA To the Hospital or Attending Physicien: within 24 hours after deals.	completely filled in by the funeral Medical Certification:	29e. Certifier (Check only one)	1∐ Certifying Ph XIX Medical Exam	niner: On the b	asis of examin				ime, dete and plec opinion, deeth occ				
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R	egistrar		DEC 282	000 4	eneva		do	and	4				

DHMH 16 Rev 6/95

**ORIGINAL** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Deta of Death 3:25pm Anna Vilone December 19 2000 4a. Facility Name (If not institution, give street end number) 4c. County of Deeth 4b. City, Town, or Location of Death Wilomico Salisbury Deer's Head Center If Under 24 Hrs. 7. Age (In yrs. last birthdey) Date of Birth (Month, Dev. Year) 9. Birthpiece (State or Foreign 1□M 2⊠F Months Days Hours Min New York 84 4/22/1916 Usual Residence of Decedent 10c. City. Town or Location 10b. County 10d. Inside City Limits Delaware Sussex Delmar 1 Pyes 2□ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 84 Golden Lane 19940 USA 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Detes: 11. Maritel Status Wes Dacedent of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, atc. 1 ☐ Never Married 2 ☐ Married White 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) College (1-4or 5+) Waitress Restaurant 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Giuseppe Bellonio Maria Rose Calarita 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Lewes, DE Anthony J. Vilone / 329 Angola by the Bay Son 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete ₽ Buriai 2 □ Cramation 3 □ Removel from Stete 4 □ Donation 5 □ Other (Spacify) St. Stephens Cemetery 12/22/2000 Delmar, DE 21. Signeture of Funeral Servica Licensae 22. Nama and Address of Fecility 13 E. Grove St Short Funeral Home Delmar, DE 19940 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceusa on each line. Approximate Intervel Betw Onset end Death Lung cancer with wide spread metastasis to Immedieta Cause (Finel diseese or condition resulting in deeth) Septemba Due to (or as e consequence of) 2000 Sequentielly list conditions, if eny, leeding to immediate causa. Entar Underlying Ceuse (Disaase or injury thet initieted events resulting in deeth) Lest Due to (or es e consequenca of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Atrial 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

pue

**Physician** 

Examiner

10e. Steta

**Funeral** 

Director

show

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funerai

Completed by

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Pages 1 end 2 should be filed within 72 hours eftar

Hygiene.

7 is marked other traumatic event,

Department of Health and Mental Important: If Item 27 is marked or any injury or other traumatic evenue.

21215-0020

Baltimore, Maryland

/Medical

the buriel-trer been signed by the attending physiclan should be detached for use es the burie in by the

has

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After

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or Attending Physician:

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records.

Physician/Medical þ Completed Be 10 Certification: To the Hospital or within 24 hours eft To the Funeral Discomplataly filled in

edicai

29a. Certifier (Check only one)

29b. Signature and titla of certifier

10 DQ

State Registrar

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension 25. Wes casa raferred to medical exeminer? 26. Piece of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 27. Menner of Deeth 28b. Time of

28a. Date of Injury (Month, Dey Year) 28d. Dascribe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Naturei 2 Accident 1 Yes 2 No 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, straet, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicida

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and piece, end due to tha ceuse(s) end mennar es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end pieca, end due to the cause(s) end manner steted.

29d. Data signed (Month, Day, Yaar) December 19, 2000

30. Nema and address of person who competed cause of deeth (Item 23e) (Type, Print)

Po BOX 2018, Salisbury, MD 21802 - 20 1 Center Head

Arrest Arrest 

				Ce	rtificate o	f Death		g. No.		2539
Physician	1. Decedent's Nema (First, Middle						Data of Death     Month	Dey	Year	3. Time of Death
/Medical	Delores	Veney	-Abusal	Liah			Decembe:	r 15 :	2000	07:20 A.M.
Examiner	4e Facility Name (If not institution					4b. City, Town, or Lo		4c. County	of Death	
	Stevens Forest					Columbi			ward	
Funeral	5. Social Security Number	6. Sax 1 ☐ M 2 ☑ F	7. Age (In yrs. 38	lest birthdey) Yrs.	Months De		8. Dete of Birth (Month, Day,	Year)	9. Birthpla Country	ce (Stete or Foreign
irector	Usuel Residence of Decedent		30	113.			11-14-19	962	Norfo	1k, VA
ector	10a. Stete 10b. County		10c. Ci	ty, Town or Lo	ocation				100	d. Inside City Limits
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Director	10e. Street and Number				10f. Zip Code	9	10	g. Citizen of V	What Country	v?
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era				IS 13	210 Was Decedent		acity Yes or No-	U.S	A . e - Americer	n fndien.
5		Armed F	orces?			of Hispanic Origin? (Spo uban, Mexican, Puarto	Rican, atc.)		k, White, et	
MD Howard  10e. Street and Number  9657 Basket Ring Rd Apt#3  11. Marital Status  12. Was Decedent Ever in Armed Forces?  1 Naver Married 2 Merried  3 Widowed 4 Divorced Yaer or Dates:  15. Decedent's Education (Specify only highest grace completed)  Elementery/Secondary (0-12)  12 th  17. Fathar's Name (First, Middle, Last)  James Bryant  19e. Informent's Name/Reletionship (Type, Print)  Theresa Higgs  20e. Method of Disposition		iva Dates:		1□ Yes 2ŪN	No Specify:		Specify	B1	ack	
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mo		College	(1-40f 5+)	Human	Resourc	e Administ	rative	Privat	te	
	17. Fathar's Neme (First, Middle,	Last)				18. Mother's Neme				9-3-L-20-LES
To B	James Bryant					Doris Ty	son			
-	19e. Informent's Neme/Reletions	nip (Type, Print)		19b. Maili	ng Address (Stre	eet end Number or Run		City or Town,	State, Zip C	Code)
	Theresa Higgs			9765	Goodluc	k Rd Lanhai	m. MD 20	706		
any injury or other tra	20e. Method of Disposition		20b. I	Plece of Dispe	osition (Neme of metory or other)			0c. Location -	City or Tow	n, Stete
5	1 XBuriel 2 Cremetion 4 Donetion 5 Other (S)		Stete		Cemeter		2-22-00 T	Washing	zton.	DC
	21. Signature of Funeral Service				2. Nama and Ad	drace of Encility				
BUG	1 / 1	( )				1 J.	B. Jenkin			iome
	23e Ports Enter the discourse	complication	havend the day	1		over Rd La			-	Approximate
	23e. Pert1. Enter the disease, or shock, or heart failure. List	only one cause on	aech line.	DO NOT BN	ter the mode of (	aynig, such as cardiac (	or respiratory erres	.,		ntervel Between Onset end Death
	Immediate Ceuse (Final			1						
al er	disease or condition resulting in deeth)	a. Con	pressie	nal	asphy	xia and injuris	d mult	iple	1	
6			Due to (	or as e conse	quence of):	injuria	25	Party.	1	
Examine		b				9			1	
Xai	Sequentially list conditions, if any, leeding to immediate	1600	Due to (	or es e conse	quence of):				1	
6	ceuse. Enter Underlying Cause (Diseese or injury that initiated events	C		OHEN TO					1	
pa	resulting in deeth) Last		Due to (d	or es a conse	quence of):				1	
ician/Medica		d								
Physician/Medic	Death Other Land		4				1 000 01111		-0-1000	Manager 14 1 11 2
/ Physician/N	Part II. Other significant condition	ns contributing to	seath but not ras	sulting in the L	indarlying causa	givan in Part I.				the cause of death?
							1 U Ye	8 ZANO	3 Proba	ably 4 Unknown
							24a. Wes en	eutopsy	24b. Wer	e eutopsy findinas
ete							perform	ed?	com	e eutopsy findings lable prior to epletion of causa
To Be Completed										eeth?
CO							1 <b>/2</b> Yes	s 2 No	120	Yes 2□ No
Be	25. Wes cese referred to medical examiner?						h (Check only one	)		
_	1 Yes 2 No		Inpatient 2		III JU DOA		me 5 Resider	34		
by the funeral	27. Menner of Deeth 1 □ Neturel 5 □ Pendin		of Injury oth, Dey Year)	28b. Time of Injury		Nork?	28d. Describe how	winjury occur	inned;	under
cat	2 Accident investig 3 Suicide 6 Could r	othe lot	-3000	071.	>	I□Yes 2⊠No	meter	n uph	ricle	
0 > =	4 Homicide determ	ined 28e. Pled	e of injury - At h	ome, rem, st	reet, fectory, offi	Ce	28f. Location (Str. City or Town,	State of d	IBIUH 10 190	HOUSE IVUITORS

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completaly filled in by the fi Medical Certifica

> State Registrar

Stephen S.
31. Date filed (Month, Day, Year)
DEC 2 2 2000

29e. Certifier (Check only one)

30. Name end eddress of person who completed cause of death (Itam 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

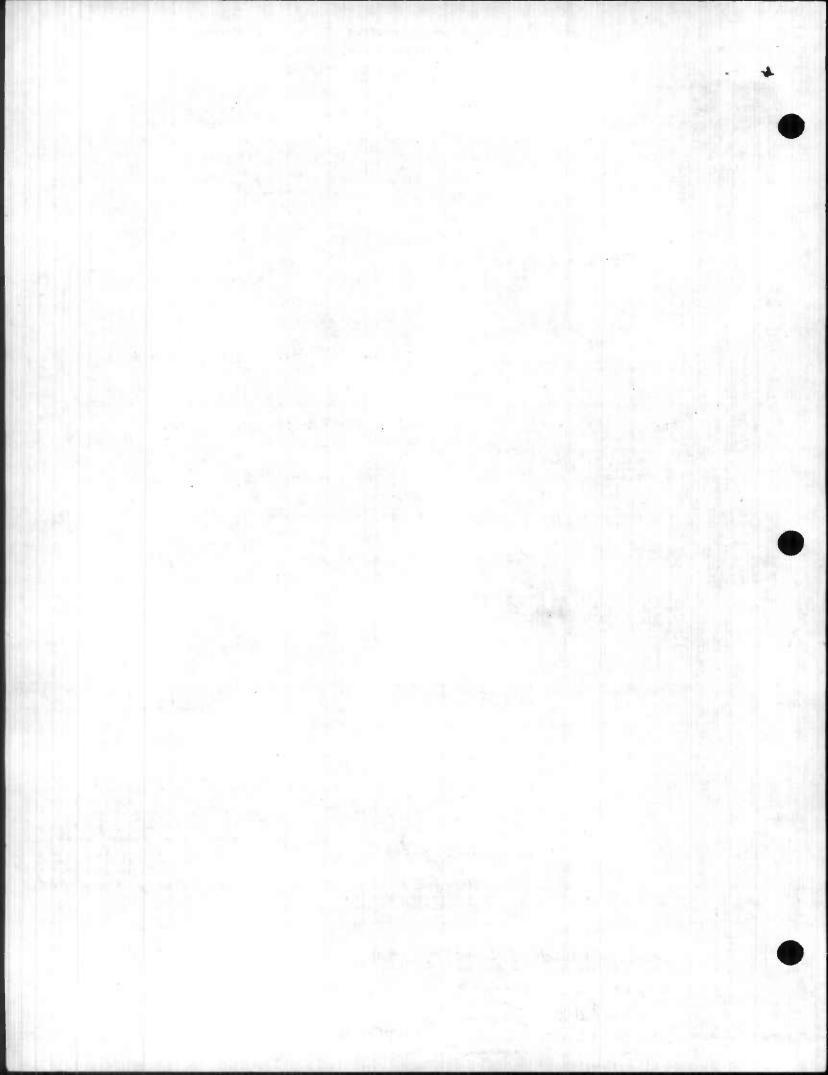
29d. Data signed (Month, Day, Year)

December 15, 2000

29c. Licansa number

O.C.M.E.

Radentz 1 32. Registrer's Signetura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Year December 20, 2000 **Physician** Agnes Virginia Wood 2:30 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year | If Undar 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2 F 88 Yrs. May 24, 1912 Director 215-26-2460 Maryland Usual Residence of Decedent tha Maryland 10d. Insida City Limits 10a State 10c. City, Town or Location 10b. County ma 23a or 28a-f ahow 1√2 Yes 2 □ No Director Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20650 22810 Dorsey Street Apt. 211 U.S.A. Funeral death 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Nema Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 6 1 Yes 2 No Specify: Specify Completed by 3 Widowed 4 □ Divorced White "natural". 15. Decedant's Education (Specify only highest greda completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Clothing Store Owner/Manager 7th 18. Mother's Name (First, Middla, Maidan Surname) 17. Fathar's Nama (First, Middla, Last) Pages 1 and 2 should be file ment of Health and Mental Hy ant: If item 27 is marked oth lury or other traumatic event Be William Albert Wood Mary Alice Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Pnnt) 4037 Knollbrook Drive, Huntsville, AL 35810 William R. McGee (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department Copartment of Important: If any Injury or other 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 12/23/00 Leonardtown, Maryland 21. Signature of Funeral Service License 22. Name end Address of Facility Mattingley-Gardiner Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death shock, or heart feilure. List only one cause on each line. P.O. Box 270, Leonardtown, Maryland 20650 Approximata Interval Between Onset and Death not enter the mode of dying, such as cardiac or raspiratory arrest, Physician /Medical Immediate Cause (Final disaasa or condition resulting in deeth) 400 dent Examiner Due to (or as a consequence of): Physician/Medical Examiner that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequenca of): 88 USB 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Unknown 1 Yes 2 No 3 Probably Records. by The law requires 24b. Were autopsy findings available prior to 24e. Was en eutopsy performed? Be Completed completion of ceuse of death? page 2 s of Vital Physician: 25. Was cese referred to medicet examiner? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) edicai Certification: To 1 Yes 2 No After this 27. Manner of Deeth
1 Natural
2 Accident 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation s after deau. 1 ☐ Yes 2 ☐ No 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral C

complately filled To the Hospital 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and dua to the ceuse(s) and manner steted. 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12-21-00 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Leonardtown, Maryland 20650 William D. Boyd, II, MD

**DHMH 16 Rev 6/95** 

State

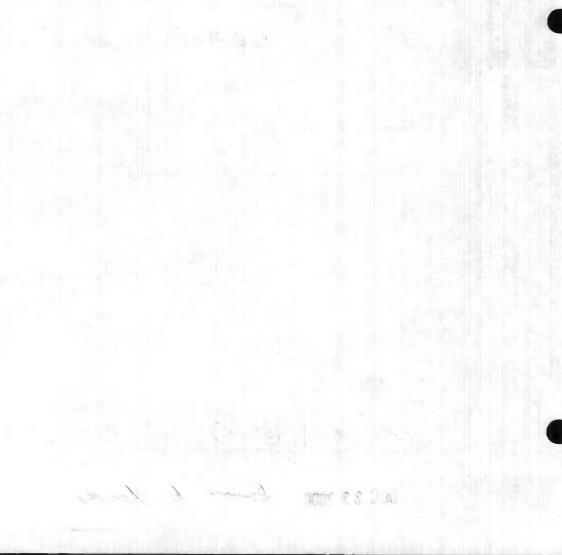
Registrar

31. Data filed (Month, Day, Year)

DEC 22 2000

32. Registrar's Signatura

Beneron



	Decedent's Name (First, Middle, Las	State of Maryla		cate of			Reg. No.	U 4	3. Time of Death
Physician	Alice Maria					Month	BER 13,	Year 2000	10:00AM
/Medical Examiner	4a Facility Name (If not institution, give				4b. City, Town, or L		1	y of Death	10.00M1
Examine	St. Mary's Hosp	ital			Leonardt	OWN		Mary's	
Funeral	5. Social Security Number 6. Se	ex 7. Age (In y		nder 1 Year	If Under 24 Hrs.	8. Date of Birti (Month, Da)	h		ce (Stete or Foreign
Director	216-22-2701	□ M 21Ž(F 75	Yrs.	nths Days	Hours Min.	March 14		Maryl	and
puet Maria	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Location					100	I. Inside City Limits
with the Maryland a or 28a-f show to notified at Director	Maryland St. Mary	's I	eonardtown						1 ☐ Yes 2 ☐ No
tor 28e-f a be notified Director	10e. Street and Number			f. Zip Code	THE STATE OF		10g. Citizen of	What Country	n
ms 23s or cmust be neral Di	23211 Bayside Ro	oad		20650		8.33	U.S.A		
al, or terms 23s samples must by Funeral	11. Maritel Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Detes:		Decedent of I specify Cub es 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra Bla Specii	ce - American ick, White, et fy: Whi	c.
ted fat	15. Decedent's Ed	ucation	16a. Decedent's	Usuel Occup	pation during most of work		16b. Kind of B	Business/Indu	stry
r, tre Made I	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	OT use retire	during most of work d)	ing			
TO TO	12th		Homema)	ker			Own H		
8 0	17. Fether's Neme (First, Middle, Last)				18. Mother's Nam			me)	
Wilmer Daniel Woodburn  19a. Informant's Name/Relationship (Type, Print)  Marvin Edward White (Spouse)  20b. Place of Disposition (Name of cametery, cremetory or other place)  1 Date 20  Charles Memorial Gardens 12/16/00 I									
Wilmer Daniel Woodburn   Alice Estelle Higgs									
19a. Informant's Name/Relationship (Type, Print)  Marvin Edward White (Spouse)  20b. Method of Disposition  20c. Method of Disposition  20b. Placa of Disposition (Name of camefery, cremetory or other place)			Road, Le						
25	1 ⊠ Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	cametery, cremetory harles Mem	orotherpla orial	Gardens ]	2/16/00	Leonar	dtown,	Maryland
ysician	23a, Part 1. Enter the disease, or composition of heart failure. List only of the state of the s		P.O eath. Do not enter the	Box mode of dyin	270, Leon ng, such as cardiac	ardtown or respiretory er	, Maryl	and 20	
aminer e	disease or condition resulting in death)		o (or as a consequence		e Co	Con.			Minh
physician and s the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	c	o (or as a consequence				All		
d by the ettending philetached for use as the Physician/Med	resulting in death) Last	d							
the ett hed for	Pert II. Other significant conditions co	ontributing to death but not	resulting In the underly	ing cause gi	ven in Part I.	23b. Did t	obacco use co	ontribute to t	he cause of death
						10	Yes 2□ No	3 Probe	bly 4 Conknow
2 should					-16-11		an autopsy rmed?	com	e autopsy tindings able prior to pletion of cause eath?
pege Poge						101	es 2 No	10	Yes 20 No
cartificata irector, per	25. Was case reterred to medical examiner?				26. Place of Dea	th (Check only o	ne)		
T T	1 ☐ Yes 2 No			J DOA		ome 5 Resid			
After funer.	27. Manner of Deeth  1 Watural 5 □ Pending	28a. Date of Injury (Month, Dey Year		28c. Inju Wo		28d. Describe t	now injury occu	irred	
the	2 Accident investigation 3 Suicide 6 Could not be		t home form alread for		Yes 2□No	28f. Location (S	Street and Al-	her or Dural	Route Number
Directify British	4 ☐ Homicide determined	28e. Placa of Injury - A building, etc. (Spe	t home, farm, street, fa ecify)	ectory, office		City or Tow		Der or nurar	noble Number,
To the Funeral Director: Affart complately filled in by the funeral Medical Certification:	29e. Certifier (Check only one) Certifying Phy Medicat Exam	reician: To the best of my liner: On the basis of exam	nowledge, death occu inetion and/or investig	rred at the ti ation, in my o	me, date and place, opinion, death occur	and due to the ored at the time,	cause(s) end m	nenner as sta , and due to t	ted. he cause(s)
Med Med	29b. Signature and title of cognier	and menner stated.		29c. Licens	se number		29d. Date sign	ed (Month. D.	ay, Year)
F 8	1/1/1/2	ton		1	4200	- 44			
in the second	30. Name end address of person who o		tem 23a) (Type, Print) LEONARDTOW		20650	100		-15-	00
State	31. Date filed (Month, Dey, Year)	32. Registrer's Sig		AT S ELD	- 20050				
State Registrar	DEC 14 2000			land.					

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State of Maryland / Department of Health and Mental Hygiene

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		Ce	rtificate d	of Death		Re	g. No.			
	1. Decedent's Neme (First, Middle, La	ist)					2. Date of Death			3. Tima of Death
Physician	Gibbons Eug	ene Woo	d				Month Decembe	Day r 7. 20	Yeer	10:05 a.r
/Medical Examiner	4e Facility Nama (If not institution, give				4b. City, To	wn, or Lo	cation of Death	4c. County		10.03 4.1
Examine.	St. Mary's Nurs	sing Center			Lec	nard	town	St.	Mary'	s
Funeral	5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday	If Under 1 Ye	ear If Under	24 Hrs.	8. Dete of Birth (Month, Pay April 2		9. Birthol	aca (State or Foreign
Director	214-12-9277 Usuel Residence of Decedent	1⊠M 2□F 7	79 Yrs.	Months Da	ys Hours	Min.	April 2	3,1921	Mary	Yand
/land	10a. Stete 10b. County	100	. City, Town or L	ocation	- m				10	Od. Inside City Limits
death with the Maryland ms 23a or 28s-f show must be notified neral Director	Maryland St. Mar	y's	Callaw	ay						1 ☐ Yes 2 ☐ No
vith the Ma tor 28e-f s be noutled	10e. Street and Number			10f. Zip Cod	de		10	g. Citizen of V	Vhat Count	iry?
A will	44655 Granddaddy	's Lane			20620		100	United	Stat	96
frer death v r items 23s other must Funeral	11. Marital Stetus	12. Was Decedent Ever	in U,S. 13.	Was Decedent If Yes, specify (		igin? (Spe	ecify Yes or No-	14. Rac	e - America	an Indian,
ar, or he	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates:		1 ☐ Yes 2 ☐			rican, etc.)	Specify	k, White, e	
ed within 72 hours ygiene. er than "natural", ft, the Modes E.	15. Decedent's E	ducetion	16a. Dec	edent's Usual Oc	cupation	t al warki	na	16b. Kind of Ba	siness/Ind	ustry
	(Specify only highest gra Elementary/Secondary (0-12)	Collaga (1-4or 5+)	life.	e kind of work do DO NOT use re	tired)	O WOIN	.,9	Civil	L Serv	vice
Hygiene. ther ther ont, the	6th Grade		Dr	iver						7100
be filed tal Hygi d other svent, I	17. Father's Name (First, Middle, Last						(First, Middle, N	faiden Sumam	(0)	
Ment Ment Price To	James	Irving	Wood	d	Kath	ryn		N	layor	
1 and 2 should be f Health and Mental i fem 27 is marked of other traumatic ave To Be	19a. Informant's Name/Relationship ( Lorraine W. Bean	(Sister)	P.O.	Box 97.	Calla	wav.	Marylan	d 20620	)	
20 0 2 2	20a. Method of Disposition  1 ☑ Burlal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	oly Face	osition (Name of ematory or other cathol	/ Cefleter ic	y <sub>12/</sub>	Date 11/2000	Great	City or To	wn, Stete , Maryland
pemit. Pag Department Important: I any Injury o	21. Signature of Euneral Service Control	nsee		Brinsf	ield F	ünera	al Home,	P.A.,	2295	5 nd 20650
	23a. Part1. Enter the disease, or comshock, or heart failure. List only								il y Lai	Approximate Interval Between
ificate be executed 3 physician and se the burial-transit edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	. /	to (or as a conse	Em	nay	110	reller	٠.		months
To Do N	resulting in death) Last	d								1
deeth ce attandii ad for use	Part II. Other eignificant conditions of	contribution to death but no	t resulting in the	underlying cause	a given in Part	1	23b. Did to	bacco uae co	ntribute to	the cause of death
the sch								2 PNo		bably 4 Unknow
gned be determined by PI	-					_				
The lew requires that sate has been signed to page 2 should be detected by P	C.O.P						24e. Was a perform		8V8	ere autopsy findings eilable prior to mpletion of cause death?
The lew page 2	March Mark						1 T Ye	s 20 No	10	Yes 2□ No
	25. Was casa refarred to medical				26 Plac	e of Deatl	h (Chack only on			
hysician is certifi if director	examiner? 1 Yes 2 No	Hospital:	2 ☐ ER/Outpati	ent 3 DOA	Other:		me 5 Reside		er (Specifi	v)
	27. Manner of Death  1 Naturat 5 Panding 2 Accident investigation	28a. Date of Injury (Month, Day Yea			Injury at Work?		28d. Describe ho			7
To the Heapital or Attending P within 24 hours after death. To the Funeral Director: After to completely filled in by the funer Medical Certification:	3 ☐ Suicide 6 ☐ Could not be datermined			treet, factory, of	fice		28f. Location (St City or Town	reet and Numb n, State)	per or Rura	l Routa Number,
Paris A	29a, Certifier 1 Certifying Pt (Check only one) 1 Medical Example 1	nyelcian: To the best of my miner: On the basis of axa and manner,stated.	knowledga, daa mination and/or i	th occurred at the	ne time, date ar my opinion, dat	nd place, ath occurr	and due to the cared at the time, d	ausa(s) and ma ate and place,	anner as si and due to	ated. the cause(s)
To the He within 24 To the Fucomplete	29b. Signeture end title of certifier	0/1	1)	29c. Lie	cense number		2	9d. Date signe	d (Month,	Day, Year)
->-0	la m	121 61	1/2	117	70	64	19	12-5	9-0	7)
1.1	30. Name and eddress of person who	completed called of death	(Item 23a) (Tun	Print)	) 0.		/	20 2		
for	James P. Jarbo	e, MD//		Hollywoo	od, Mar	yland	d 20636			
State Registrar	31. Date filed (Month Year)	32. Registrar's	Signature	1						

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Lest) 2. Data of Death **Physician** December 5, Thelma Wathen 2000 8:00 AM /Medical 4a Facility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Sacurity Number 6 Sax 7. Age (In yrs. last birthdey) Birthplaca (State or Foreign
Country) **Funeral** Months 1□ M 250 F 215-38-6614 Yrs. 88 April 20, 1912 Maryland Director Usual Residence of Decadent the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f ahow 1 ☐ Yes 2 ☒ No Directo St. Mary's Maryland Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Exprene must be r 20650 USA 22487 Bull Road Funerai 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Maryland 21215-0020 1 Yes 2 No Specify: þ White 3 ☑ Widowed 4 ☐ Divorced the Medical Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Heelth and Mentel Hygiene. Ith end Mentel Hygiene. 27 is marked other than ' traumatic avent, the Men Elementery/Secondary (0-12) College (1-4or 5+) 8th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Crain Tippett Amanda Drury Parren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2: Depertment of Heelth er Important: if item 27 ia any injury or other traugings. Kenneth Wathen (Son) P.O. Box 276, Leonardtown, Maryland 20650 Baltimore, 20b. Placa of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) 12/9/2000 Leonardtown, Maryland St. Aloysius Cemetery 22. Name and Addrass of Facility
Brinsfield Funeral Home, P.A. Edward N. Brins 1eld. JR. M00052 22955 Hollywood Road, Leonar 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. 22955 Hollywood Road, Leonardtown, Maryland Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed 68760 the

Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest by Be Completed

given in Pert I. Part il. Other significant conditions contributing to death but not me

23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yas 2 No

24b. Were eutopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one)

1 □ Yes 2 □ No

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Natural

5 Pending Invastigation

6 Could not be

28a. Date of Injury (Month, Dey Year) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier

2 Accident

3 Suicide

4 Homicide

rtifying Physician: To the pest of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end manner es stated.

In medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s)

29b. Signature and title of certifier

2000

License number D 06419 29d. Date signed (Month, Dey, Year) 12/5/2000

cause of death (Item 23s) (Type Print 30. Name and address of person who comp

J. Patrick Jarboe, MD 31. Date filed (Month, Dey, Year) DEC 11

32. Registrar's Signature

Hollywood, Maryland 20636

State Registrar

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After

efter death.

To the Hospital within 24 hours or To the Funeral Completaly filled

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Certification: To

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Division

Hospital or Attanding Physician:

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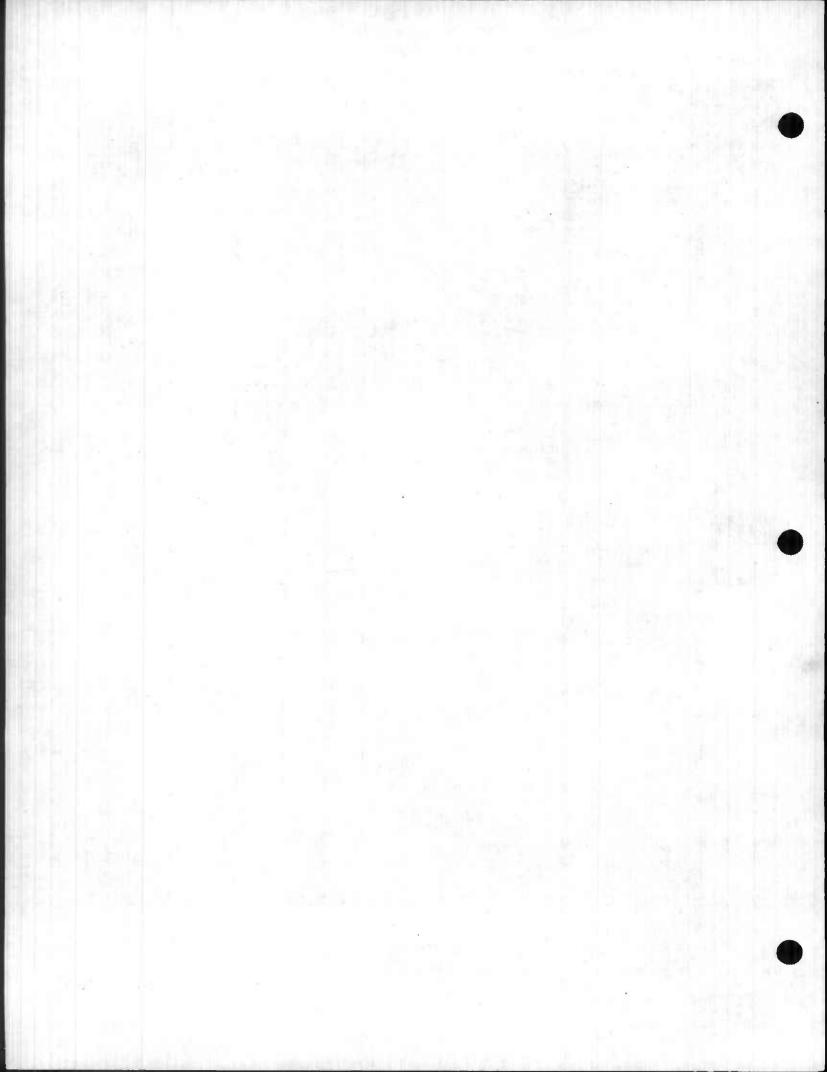
#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

rn nknown 00-	-35	52 Raymond Wolf	State of Ma	ryland		rtment of I		Mental Hy	rgiene	1;	2544
		Decedent's Name (First, Middle, Last,	)		1 10			2. Date of De		-	3. Time of Death
Physicia	ın		Raymon	d Do	hort	Walf		Month	Day Der 23, 2	Year	12.10 A M
/Medic	_	4a Facility Name (If not institution, give		u KU	Derc	WOII	4b. City, Town, or L	Decemb			12:10 A.M
Examin	er	4720 Williamsbur									t-a-a
			-			If Under 1 Yaar	Hurloc			rches	
Funeral Director		5. Social Security Number  286-46-6738  Usual Residence of Decedent	X 7. Age	(In yrs. les	Yrs.	Months Days		8. Date of Bi (Month, Da Nov. 1	7,1964	9. Birthp Coun 0 h i	lace (State or Foreign try)
ith with the Meryland 23a or 28a-f show		10a. State 10b. County MD Dorche		10c. City, 1	Town or Loc	ation	Hur	lock		1	0d. Inside City Limits
the 1	20	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Coun	try?
with w	5	4720 Williamsb	una Doad				21643		United		
est 23	era			2.11 ci ses	42.14	les Decedent et		nacih: Van ar N		a - Amaric	
21215-0036  d within 72 hours after death with the Meryland glene. w than "naturel", or ferms 23a or 28a-f show in Mexical Exercities.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Examed Forces?  1 Yes 2 Notif Yes, Give Year or Dates:			Yas, specify Cub	Hispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	Specify	k, White,	
2 hc 22 hc	e e	15. Decedant's Edu	cation		16a. Decede	ent's Usual Occu	pation during most of world	kina	16b. Kind of Bu	siness/Inc	dustry
212 Ph 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+	1	_			Nu iy			
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Iryland 21215-C should be filed within 72 h of Mentel Hygiene. marked other than "natu	Bec	17. Father's Nama (First, Middle, Last)					18. Mother's Nan	ne (First, Middle	, Meiden Sumem	10)	
ld be ked of covering the design of the desi	TOB	Robert Wolf					Margar	et Cle	eer		
Maryland  2 should be file th and Mentel Hy 7 is marked othe treumetic event	-	19a. Informant's Name/Relationship (T)	/pe, Print)		19b. Mailing	Address (Stree	at and Number or Ru			Stete, Zip	Code)
CHAL		Terri Lynn Wol	f/ Spous	e	4720	Will'	iamsburg	Rd.,	Hurloc	k, M	D 21643
the Head	-	20a. Method of Disposition		20b. Plac	e of Dispos	ition (Name of		Date	20c. Location -	City or To	wn, State
Baltimore, semit. Pages 1 ar Department of Hea mportant: if item: My injury or othe		1XDBurial 2 ☐ Cramation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Uni	tv-W	a shingt	ton Cem.	12/28	Hurloc	k. M	aryland
altim nit. Pa artmen ortant: injury	-	21. Signature of Funeral Service Licens			•	Name and Addr					
Baltil permit. Popartm importar eny injui		Tab of A	61		Fi	ramptor	m-Hawkin	s-Esko	w Fune	ral	Home, PA
		Michael t-	4skin		PO	Box 43	3. Feder	alsbur	q, MD	2163	2
Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Smu	ok.	e a corrisedo	In	rala	tion	an	l	Approximate therval Between Onset and Death
be ted	들		b. 1 N	9	rva		Tall	Mile	-5		
COrds, P.O. Box 68760, requires that the death cardificate be executed been signed by the attending physician and should be deteched for use as the bunel-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C	ue to (or a	s a consequ	ence of):	3				
ficete ficete physics the	<u>≅</u>	that initiated events resulting in death) Last	D	ua to (or a	s a consequ	anca of):				i	
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BOX beth cert attendin for use	a l										
o de de la del de la de la de la de la de la de la de la de la de la de la de	Sic	Part II. Other significant conditions cor	ntributing to death but	not resulti	ng in the un	darlying causa g	ivan in Part I.	23b. Dic	tobacco use po	ntributs to	the causs of death?
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ecords, P.O law requires thet the as been signed by th 2 should be detech	P									T	
Records, le law requires to has been signe	Completed								s an autopsy iomed?	av	ere autopsy findings ailable prior to
	De								/		mpletion of cause death2
The law	E							102	Yes 2□No	19	Yes 2□ No
of VItal Re Physician: The la r this certificate has anal director, page 2	BeC	25. Was case referred to medical		-			26. Place of Dea	th (Check only	one)		
Of VIta Physician: rhis certific rral director,	ToB	examiner? 1 XYes 2 No	Hospital:	t 2 🗆 EF	R/Outpatient	3□ DOA O				er (Specif	) at scene
O P in in in in in in in in in in in in in		27. Manner of Death	28a. Date of Injury	2	8b. Time of	28c. Inju			how injury occur		" at scelle
O Harring on the standard	달	1 ☐ Natural 5 ☐ Pending investigation	(Month, Dey		Injury 11:21		onk? ⊒Yes 2√∑No	Ha	use	Fi	CP
Miten dea ctor ctor y the	fice	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur							per or Rura	I Route Number,
DIVISION OF for Attending Physiatre death. Director: After this d in by the funeral di	Certification:	4 Homicide	building, etc.	(Specify)	Home						lliamsburg
ours erai filled		29a. Certifier 1□ Certifying Phys	elcian: To the best of	my knowle					urlock,		
DIVISION O To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical		ner: On the basis of e	xaminatio							
ithin of the sample sample	Ž.	29b. Signature and title-of certifier /	and manual state		1	29c. Licer	nse number		29d. Date signe	d (Month.	Dey, Year)
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	- 4	no plant and politica at the process who are		- AL MAN O							

State Registrar

31. Date find (Month, Dey, Year) Pestaner 32 Ragistrar's Signatura

111 Penn Street, Baltimore, Maryland 21201



00-7394-019 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. crn State of Maryland / Department of Health and Mental Hygiene Unknown 00-353 Certificate of Death Cody Wolf 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 23, 2000 8:00 A.M. Physician December Cody James Wolf /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 4720 Williamsburg Road Hurlock Dorchester If Under 24 Hrs. 6. Date of Birth (Month, Day, Year) 0 Ct. 13, 1991 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days M 2□ F 9 Yrs. 212-35-0913 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Dorchester Hurlock 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? United States 4720 Williamsburg Road 21643 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 72 hours efter 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 8 Maryland 21215-0036 1 Yes 2 No Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Cottege (1-4or 5+) Elementery/Secondery (0-12) N/A nd 2 should be filed ville end Mental Hygie 27 is marked other of traumatic event, to other 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be permit. Peges 1 and 2 should be Department of Health and Mental Important: If item 27 is marked c any lightry or other traumatic evi-page. Raymond Robert Wolf Terri Lynn Saathoff 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiting Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Terri Lynn Wolf/Spouse 4720 Williamsburg Rd., Hurlock, MD 21643 altimore, 20b. Plece of Disposition (Neme of 20c. Location - City or Town, State Dete 20e. Method of Disposition etery, cremetory or other plece) 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Unity-Washington Cem. 12/28 Hurlock, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Framptom-Hawkins-Eskow Funeral Home, PA Eskow PO Box 43, Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervet Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examine Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of) 98 180 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? o 1 Yes 2 No 3 Probably 4 Unknown 0 Records. à 24b. Were sutopsy findings aveilable prior to 24a. Was an autopsy performed? peed s Completed completion of cause of death? The law has page 2 1 PYes 2 No certificete 1 Yes 2 No Division of Vital Physician: Be 25. Wes case referred to medicel examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 X1 Other (Specify) at scene 2 1 XYes 2 No After this funeral 28b. Time of Injury 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 1 Neturel 5 Pending investigation House deeth. 12-22-2000 11:21 P M 1 Yes 2√2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4720 Williamsburg 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Home Road, Hurlock, Maryland 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. edical (Check only

within 24 hours after deeth To the Funeral Director: , completely filled in by the

State Registra

29b. Signeture and title of certifier

31. Date filed (Mighth, Dey, Year)

2 8

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

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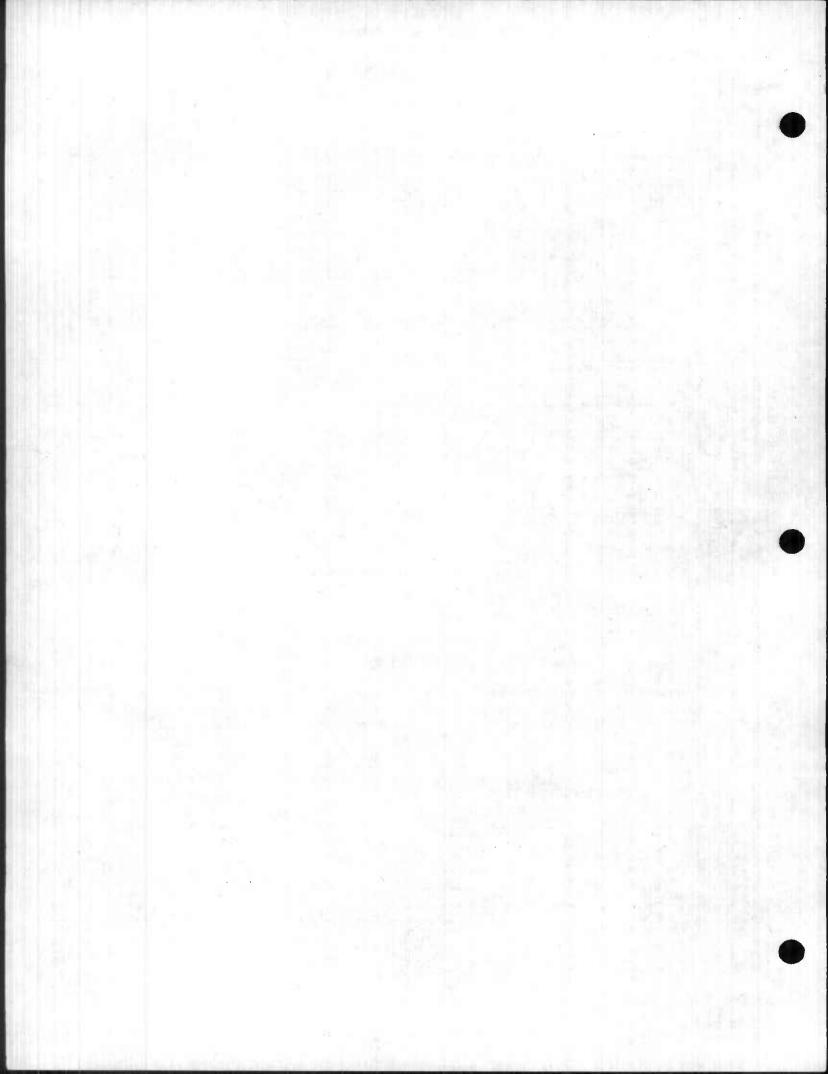
29c. License number

O.C.M.E.

taner 111 Penn Street, Baltimore, Maryland 21201

29d. Dete signed (Month, Day, Year)

December 24, 2000

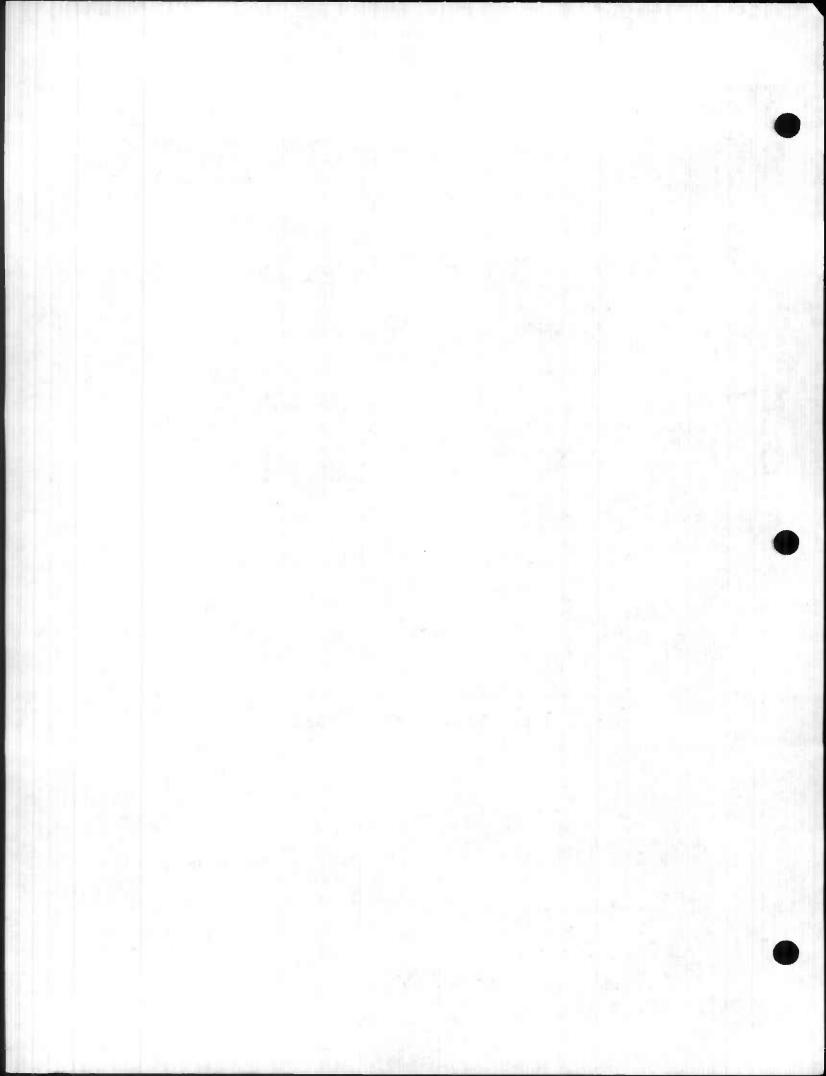


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State of Maryland / Department of Health and Mental Hygiene

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ysician	_	Judith Ivy Whit	lock.								Month Decembe	Dey		(eer	17:10	
ledical aminer	- 1	la Facility Neme (If not institution, g		number)					4b. City, To		cation of Deat		County of		17.10	
HILLET		Union Hospital	of Coo	il Coun	+ 17				E1kto	-		Co	041			
			. Sex		vrs. lest birti	hday)	If Under		If Under	24 Hrs.	8. Date of Bir (Month, De		cil	9. Birtholac	e (State or	Foreiar
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	-	10a. Stete 10b. County		10c	. City, Town	or Loca	ation							10d.	Inside City	Limits
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1	+	Maryland   Cecil		IN:	orth 1	east	10f. Zip	Code	1			10a. Citiza	en of Wh	et Country	?	-
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Š	5	11. Merital Status	Arme	d Forces?	in 0,3.	IS. W	Yas, spe	cify Cub	an, Mexicar	n, Puerto	Rican, etc.)			White, etc.		
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	-			or Detes:								1 401 15		White		
		15. Decedent's (Specify only highest of	Education grade complet	red)	16a.	(Give k	ent's Usu	el Occu urk done	pation duning mos id)	t of worki	ing	16b. Kin	d of Busil	iness/Indus	itry	
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0	2	unknown							unkn	own						
		19a. Informent's Name/Relationship	(Type, Print)		19b.	Mailing	Addres:	s (Stree	t and Numbe	er or Rura	I Routa Numb	er, City or	Town, St	tete, Zip Co	ode)	
		David Whitlock /	Son		48	No	rth	Lock	cwood	Road	, Elkto	on, Ma	ary1	and 2	1921	
	2	20e. Method of Disposition	4-1-6-3		b. Plece of	Disposi	ition (Ne	me of	ica) D	1	Data	20c. Loc	ation - Ci	ity or Town	, State	
		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spe	North I					DE		er 28,	Month	. For	- M	1	3	
		21. Signature of Funeral Service Lic		NOLLII I	East P				ess of Fecili		2000	NOTLI	1 Eas	st, M	aryla	na
		VIII AII	77 (	/							, 127 8	South	Main	n Str	eet.	
		Moter - (	New			No	rth :	East	, Mar	ylan	d 2190	L				
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														0	nset end D	aatn
		Immediate Ceuse (Finel disease or condition	Co	robem	MANAU	Car	, 4	cci	dont	•				1	Deur	
		resulting in deeth)	e	reptor Due lelasta	to (or es e c	consequ	uenca of):		06/11		515				0	
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Physician/	5															
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		4 ☐ Homicide determine	A 200. F	lece of Injury - , uilding, atc. (Sp	At home, fai <i>ecify)</i>	rm, stre	et, factor	y, office	137		28f. Location City or To	wn, Stete)	i Number	r or Hurai H	toute Numt	w.
edicai	3	29e. Certifier 1 ☐ Certifying   (Check only 2 ☐ Medical Ex	Physician: To	the best of my	knowledge,	, deeth	occurred	at the t	ime, date er	nd plece, o	end due to the	cause(s) a	and man	ner es stete	ed.	
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		180	agen	8no			3	23	322	-		10	2.20	6.00	)	
	-	30. Name end address of person wh	o completed	cause of death	(Item 22a) (	Type P										
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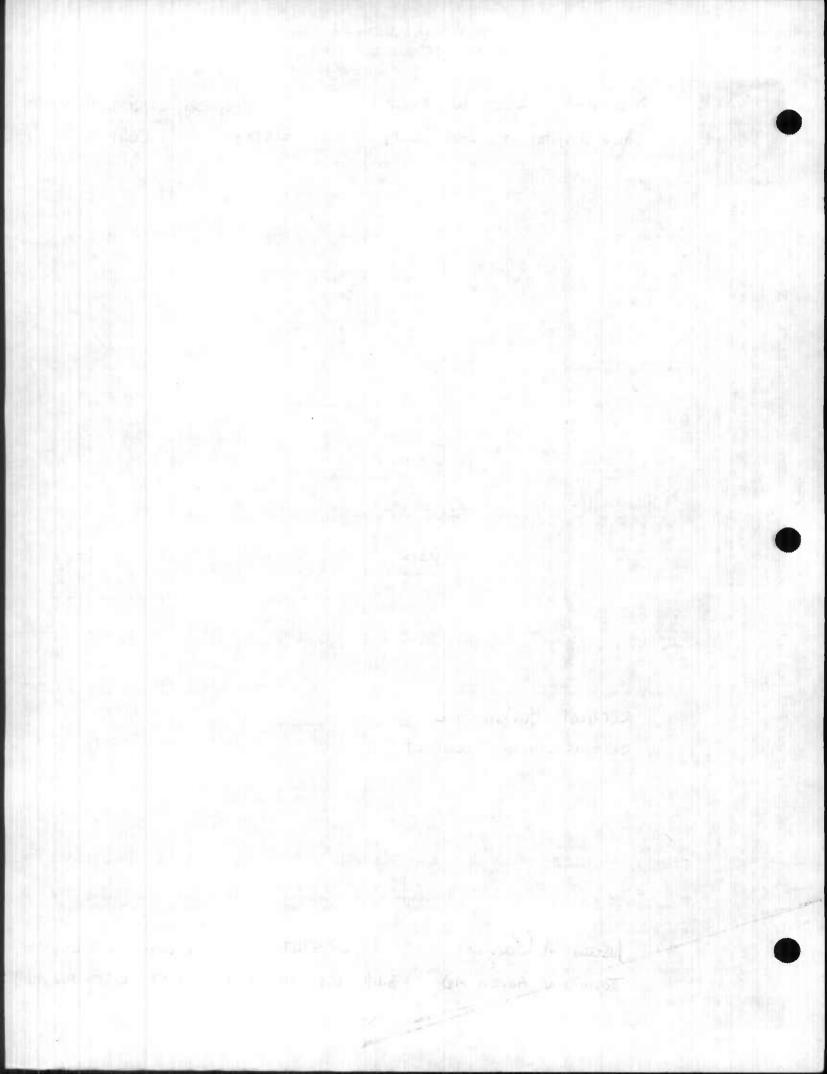


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State of Maryland / Department of Health and Mental Hygiene

42547

				Jenifica	ate of	Death			Reg. No.		
Physician /Medical	1. Decedent's Name (First, Middle, L Margaret		Work	MGN				2. Dete of De Month Decem	ber, 23,		3. Time of Death 10:02AM
Examiner	4e Facility Name (If not institution, gi		Cecil Co			E	三十二		(	Cecil	
Funeral Director	215-42-1029	Sex 7. Ag	e (In yrs. lest birth	Month	der 1 Year ns Deys	If Under Hours	24 Hrs. Min.	8. Dale of Bir (Month, De July 2	th ey, Year) 5,1944	9. Birthp Coun	place (State or Foreign http:) Maryland
pu &	Usuel Residence of Decedent  10a, Stete 10b, County		10c. City, Town	or Location						1	Od. Inside City Limits
or 28=1 show be notified at Director	Maryland Cec	il		T		yvil1	.e				NXYes 2□No
Direction of the transfer of t	10a. Street and Number 404 Concord Apart	monts		101.	Zip Code 219	903		17.00	10g. Citizen of \	J.S.A	
free deeth w	11. Marital Status	12. Was Decedent	Ever in U.S.	13 Wes De			gin? (Sp	ecify Yes or No		a - Americ	
5-0020 72 hours after deeth with the Maryland natural; or Nema 23a or 28a-f show deal Examiner must be notified at each by Funeral Director	1 Never Merried 2 Married	Armed Forces?  1 Yes 2 1  If Yes, Give Yeer or Detes:		If Yes, s	pecify Cube	Specify:	, Puerto	Rican, etc.)		ck, White,	etc. hite
5-00; 72 hours netural', sea Eur	15. Decedent's E	ducation	16a. [	Decedent's U Give kind of life. DO NO	sual Occup	ation	t of work	ina	16b. Kind of B		
1 21215-0 ed within 72 ho byglene. The Magnell rt, the Magnell Completed	Elementery/Secondery (0-12) Twelve Years	College (1-4or 5	1+1	Nursin					1		ial Hospital e, Maryland
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	19e. Intorment's Neme/Reletionship Neil E. Huss (sor							al Route Numb le, Mar	yland 2	State, Zip 21903	
S To E	20a. Method of Disposition  **CABuriel 2			Disposition (I cremetory of rel1 Ce	or other ple		1:	Date 2/27/00	20c. Location -		own, Stete t, Maryland
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Physician /Medical Examiner	Immediate Cause (Finel disease or condition		seps	2						1	1 day
	resulting in deeth)	3/12/11	Due to (or es a co	onsequence	ot):					1	
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X es es	resulting in death) Lest	d	Due to (or as a co	nsequence (	of):						
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	eervical	caraina	Ma					10	Yss 2 No	3 Pro	bably 4 Unknown
aw requires to the second as t	o 6 L 6 p. Lo.	vascular	acciden	+				24a. Was perf	s an autopsy ormed?	ev	ere eutopsy findings reliable prior to empletion of cause death?
The I								10	Yes 2 No	1[	☐ Yes 2☐ No
VITAL Ridden: The Liceton, page	25. Wes case reterred to medical exeminer?	Name to 1					of Deat	h (Check only	one)		
F S S D	1 ☐ Yes 2 ☑ No 27. Menger of Death	Hospitel: 1 Inpatie			DOA Oth	4U Nt	rsing Ho		idenca 6 Oth		(y)
Division of Vital or Attending Physician: The after death. Director: After this certificate in by the funeral director, pg entification: To Be Co	1 Neturel 5 Pending 2 Accident investigation		y Year) 28b. Ti	me of ury M	28c. Injui Wo	rk? Yes 2□	No	28d. Describe	how injury occur	red	
DIVI	3 Suicide 6 Could not determined	28e. Pleca of Injury	ury - At home, feri c. (Specify)	n, street, fac	tory, office				(Street end Num. own, Stete)	ber or Run	al Route Number,
Division o  To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29e. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of miner: On the basis of and manner ste	examinetion end	deeth occurr or investiget	ed at the tir	me, date an opinion, dee	d plece, th occur	end due to the red et the time	ceuse(s) end m , dete end placa,	enner as s and due le	steted. o the cause(s)
To the To the comp	29b. Signeture and title of cartifier	M. Boron.	cm		29c. Licens	e number	7)		Decemb		7, 2000
5	30. Neme and address of person who			ype, Print)	te 10	1	1) (	West t	to upit	Elh	How Marybu
State Registrar	31. Dete filed (Month, Dey, Year) DEC 2 6 200		ar's Signeture	Sp	arks	,					



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. Amend Item 1 per Phy. State of Maryland / Department of Health and Mental Hygiene 12/18/2000, Carroll County, wjl Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth GLADYS IRENE WHITED Month **Physician** 0700 2000 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Westminster
H Under 1 Year H Under 24 Hrs. 8. Date of E Carro Hahn Koad 0 Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. lest birthdey) 5. Sociel Security Number **Funeral** Year) 1 M XXF Days Hours Yrs 216-01-9849 87 Sept Director VA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits itel Hygiene. d other than "naturel", or items 23s or 28s-f show event, the Medical Exemples must be notified at 10a. Stete 10b. County 1 Yes 2 No Director MD Carroll Westminster 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 126 Hahn Road 21157 USA Funeral death 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Merital Stetus Bleck, White, etc. filed within 72 hours after 1 Pes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Homemaker Own Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Peges 1 and 2 should be file Depertment of Health and Mentel Hy Important: if them 27 is marked oth eny Injury or other traumatic event acts. Be Mary Caroline (Unknown) Daniel Shaffer 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Violet Street/Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) MD 21074 Hampstead 12/15/2000 Location - City or Town, State 20a. Method of Disposition DEBurial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Meadow Branch Cemetery Westminster, MD 22. Name and Address of Fecility
Pritts Funeral Home and Chapel P.A.
Post Westminster, MD21157 21. Signature of Funerel Service Licentary Approximete Interval Between Onset end Death 23a Part. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel Coronary vasculardisease disease or condition resulting in death) Examiner Due to (or as e consequenca of) Examiner sician and burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequenca of) Box 68760 Physician/Medical the Due to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. Completed by 24b. Were autopsy findings 24e. Wes en autopsy evailable prior to completion of cause of deeth? certificate has The 281No 1 ☐ Yes 2 No 1 Yes Attending Physicien: 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo this 28c. Injury al Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After Division Neturel 2 Accident 5 Pending deeth. 1 ☐ Yes 2 ☐ No estigetion efter deeth Director: Colld not be 3 Suicide 28f. Location (Street end Number or Rure! Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 6 To the Hospital of within 24 hours of To the Funerel Completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) and menner as stated.

[In the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) and menner as stated.

[In the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated. Medical and manner stated 29b. Signeture Ruzbarsky mb 29c. License number 29d. Date signed (Month, Day, Yeer) RUZBARSKY, M.D. leted cause of death (Item 23a) (Type, Print) Philip 30. Name and eddress of person who comp J 25 Air tminster, rive 31. Date filed (Month, Day, 32. Registrar's Signal DEC 14 2000 Registrar

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		State of Maryl		ertificate			jiene () (	42549
	1. Decedent's Name (First, Middle, Last,	)				2. Date of Deal	th	3. Time of Death
Physician /Medical	Arthur Lev	i Wilhelm				Dec 15		1412
Examiner	4a Facility Name (If not institution, give		444		4b. City, Town, or		4c. County of	
	Carroll County Ger	neral Hospit	tal		Westmir		Carr	
Funeral Director	210-30-3304	7. Age (In )	yrs. last birthday Yrs.	Months Da				). Birthplace (State or Foreign Country) Maryland
ist death with the Maryland thems 23a or 28a-f show the must be notified at furneral Director	Usuel Residence of Decedent  10a. State 10b. County  Maryland Baltimore		. City, Town or I	Location	Sparks			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
or 28s-1. De notifie	10e. Street and Number		gual e	10f. Zip Cod			0g. Citizen of Wh	
ra int	16317 Yeoho Road	MONEY OF STREET			21152		US	
Examiner must by Funeral	11. Marital Status  12 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 No it Yes, Give Year or Detes:	in U,S. 13	Was Decedent If Yes, specify ( 1 ☐ Yes 2√2)	of Hispanic Origin? (S Cuben, Mexicen, Puer No Specify:	Specify Yes or No- to Rican, etc.)		American Indien, White, etc. USA
ited ited	15. Decedent's Edu	cation	16a. Dec	edent's Usual Oc	cupation	deina	16b. Kind of Busin	ness/Industry
completed	(Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4or 5+)			one during most of wo tired) ce Person	in ing	Apartme	ent Complex
Bec	17. Father's Name (First, Middle, Last)					me (First, Middle, I	Maiden Sumeme)	
To	Albert S. Wilhelm				Leona	Jones		
	19a. Informant's Name/Releflonship (Ty Dorothy R. Curtis				reet end Number or R Road, Spa			ete, Zip Code)
	20a. Method of Disposition  1 ☐ Buriel 2 ② Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)		cemetery, cr	position (Neme or emetory or other 1 Cremat	place)	Date 12/18/ 2000	20c. Location - Ci	ty or Town, State
any in	21. Signature of Fuperal Service Licanson	10 CM007	23 .	22. Name and Ad 934 Sc	ddress of Facility outh Main		neral Hostead, MI	
	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the cause on each line.	deeth. Do not e	nter the mode of	dying, such as cardia	c or respiratory err	est,	Approximate Interval Between Onset end Death
ician dical niner	Immediate Cause (Final disease or condition resulting in deeth)	*-	moura no (or as a cons					3 days
je je	JES South ites	Due	to (or as a cons	equence or).				
cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 1	o (or es a cons	equence of):				1
Physician/Medic	that initiated events resulting in death) Last	Due f	o (or es e conse	equence of):				
d for	Part II. Other significant conditions cor	ntributing to death but not	resulting in the	underlying cause	oiven in Part I.	23b. Did to	obacco use contr	ibute to the cause of death?
should be detached leted by Physic	7.1.	ouc				1 🗆 Y		Probably 4 Unknow
page 2 should b	. ,					24a. Was a parlon		24b. Were autopsy findings evailable prior to completion of cause of death?
te has						1 U Y	es al No	1 ☐ Yes 2 ☐ No
director, page for Be Com	25. Was case referred to medical				26. Place of De	ath (Check only or	ne)	
	examiner? 1 Yes 2 No	lospital:	2□ ER/Outpati	ent 3 DOA	Other:	Home 5 Resid		(Specify)
	27. Menner of Death  1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Yea	r) 28b. Time Injury		Injury at Work? 1 Yes 2 No	28d. Describe h	ow injury occurred	
Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, ferm, secify)	street, fectory, off	ica	28f. Location (S City or Town		or Rural Route Number,
completely filled Medical Ce	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, dea nination and/or i	ath occurred at th investigation, in n	e fime, date end plec ny opinion, deeth occ	e, end due to the c urred et the time, d	ause(s) end manr late and place, an	ner as stated. d due to the cause(s)
To the Funeral completely filled	29b. Signature and title of certifier			29c. Lic	ense number	2	29d. Date signed (	(Month, Dey, Year)
	30. Name and address of parson who co		(Item 23e) (Type		11 5311		121151	<b>Ω</b> ο
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	0.11			1	uster, ml	). 21157	M. Nas	sir MD

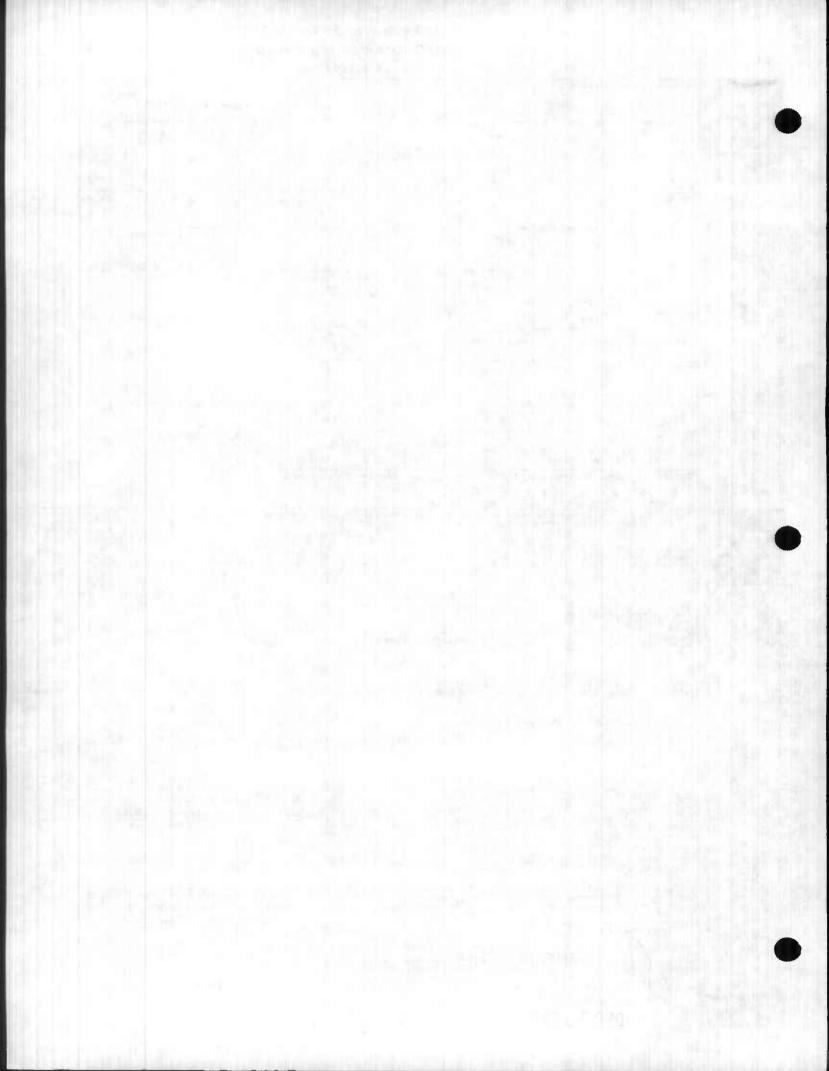
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31. Date filed (Month, Day, Year)

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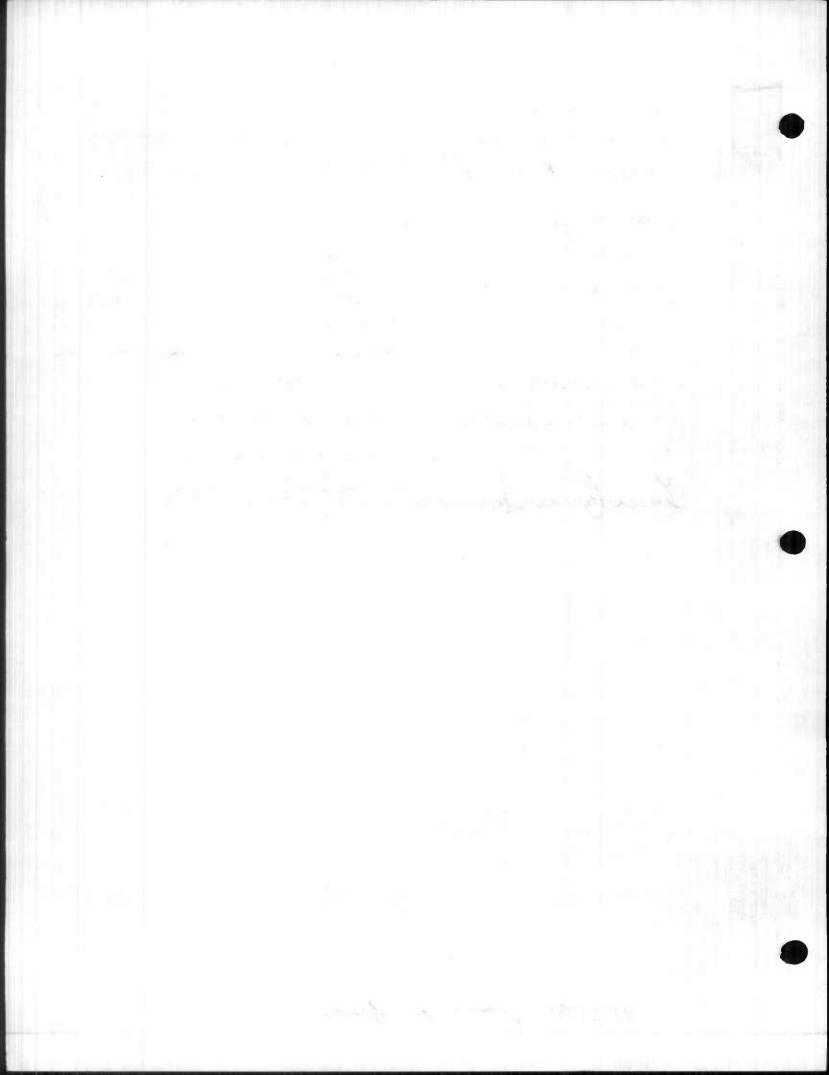


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State of Maryland / Department of Health and Mental Hygiene

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Reg. No.						

| Director    21.3 - 22 - 75.50   10.5 county    th ter thplace (Stata or Foreign ountry) Tyland  10d. Inside City Limits 1  Yes 2 No ountry?  arican Indian, te, etc.  hite  Vindustry  acturing  Zip Code)   |
|--|---|
| Donald Phillips Winterling Examiner  Fundal  | th ter  thplace (Stata or Foreign ountry)  10d. Inside City Limits 1 Yes 2 No  ountry?  arican Indian, te, etc.  hite  Vindustry  acturing  Zip Code)         |
| 46. Feeling Name (If not institution, plus stored and number)  Dorchester General Hospital  5. Social Security Number  2.13—22—7559  3. May 21 F. 7. Age (In yrs. list brindsay)  10 City, Tom or Location  10 State  10 City, Tom or Location  Maryland  Dorchester  Cambridge  10 City, Tom or Location  10 State  10 City, Tom or Location  11 Marial Status  12 Mas Devoted and Number  206 Oak St.  11 Marial Status  12 Mas Devoted and Ever in U.S.  Affect Foreign State  13 Devoted and Number  206 Oak St.  11 Marial Status  12 Mas Devoted and Dorchester  12 Marie Foreign State  13 Devoted and Number  206 Oak St.  14 Marie State  15 Devoted and Number  207 October Marie City, Very or Column  16 Devoted and Marie  17 Marie Foreign State  17 Marie Foreign State  18 Devoted and Marie  19 Devoted All Dorchester  19 Devoted All Dorchester  19 Devoted All Dorchester  10 Devoted All Dorchester  11 Devoted All Dorchester  12 Devoted All Dorchester  13 Devoted All Dorchester  14 Dorchester  15 Devoted All Dorchester  16 Devoted All Dorchester  17 Devoted All Dorchester  18 Devoted All Dorchester  19 Devoted All Dorchester  19 Devoted All Dorchester  19 Devoted All Dorchester  19 Devoted All Dorchester  10 Devoted All Dorchester  10 Devoted A | tter  thiplace (State or Foreign ountry)  Tyland  10d. Inside City Limits 1  Yes 2 No  ountry?  arican Indian, te, etc.  hite  Vindustry  acturing  Zip Code) |
| Social Security Number   Company   Social Security Number   Company   Social Security Number   Company   Social Security Number   Company   Social Security Number   Company     | thplace (Stata or Foreign cyland)  10d. Inside City Limits 1 Yes 2 No country?  arican Indian, te, etc.  hite  Undustry  acturing  Zip Code)                  |
| 213-22-7559   10   Mail Pendemon of Decoder   100. County   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100. State   100. County   100. City, Town or Location   100. City, Town or    | 10d. Inside City Limits 1   |
| Maryland   Dorchester   Cambridge   100, Zipcode   100, Citizen of What C   206 Dak St.   11. Marital Status   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specify Yes or No-Horse Floar, etc.)   14. Race - Am Bleck, White The Status   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specify Yes or No-Horse Floar, etc.)   14. Race - Am Bleck, White The Status   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specify Yes or No-Horse Floar, etc.)   14. Race - Am Bleck, White The Status   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specify Yes or No-Horse Floar, etc.)   14. Race - Am Bleck, White The Status   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specify Yes or No-Horse Floar, etc.)   14. Race - Am Bleck, White The Status   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specify Yes or No-Horse Floar, etc.)   14. Race - Am Bleck, White The Status   12. Was Decedent Ever in U.S.   14. Race - Am Bleck, White The Status   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specify Yes or No-Horse Floar, etc.)   14. Race - Am Bleck, White The Status   12. Was Decedent Ever in U.S.   14. Race - Am Bleck, White The White The Status   14. Was Decedent Ever in U.S.   14. Race - Am Bleck, White The Whi   | 1 □ Yes 2 No country?  arican Indian, te, etc.  Thite  Undustry  acturing  Zip Code)  |
| 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Machinist  Can Manuf  Tr. Father's Name (First, Middle, Last)  William F. Winterling, Sr.  199. Informant's Name/Fleationship (Type, Pirnt)  Florence Ann Winterling/Spouse  200. Place of Disposition  100 During to Specify or of the property of the prop | ountry?  arican Indian, te, etc.  thite  Undustry  acturing  Zip Code)  |
| 15. Decedent's Education (Specify only highest grade complated)  (Specify only highest grade grade grade)  (Specify only highest grade grade)  (Specify only highest grade grade)  (Specify only highest grade grade)  (Specify only highest grade grade grade)  (Specify only highest grade grade)  (Specify only highest grade grade)  (Specify only highest grade grade)  (Specify only highest grade grade)  (Specify only highest grade)  (Specif | arican Indian, te, etc.  Town, Stala  |
| 16a Decedent's Usual Occupation (Give kind of broad from the first, Middle, Last)   16a Decedent's Usual Occupation (Give kind of sort from the first, Middle, Last)   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   18b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Do Not near that a 10 contains of the first of the fir   | te, etc.  hite  /Industry  acturing  Zip Code)  |
| 15. Deceder's Education   16. Kind of Business   16. Kind of Busin   | Zip Code) Town, Stala   |
| Elementary/Secondary (0-12)   College (1-for 5-4)   Machinist   Machinist   Can Manuf   Machinist   The state of the sta   | Zip Code)<br>Town, Stala  |
| 18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumame)   19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 206 Oak St., Cambridge, MD 21613   20a. Method of Disposition   18. Mother's Name (First, Middle, Maiden Sumame)   19a. Informant's Name-Relationship (Type, Pint)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 206 Oak St., Cambridge, MD 21613   20a. Method of Disposition   18. Mother's Name (First, Middle, Last)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 20b. Place of Disposition (Numa of Oak)   2   | Zip Code)<br>Town, Stala  |
| 19. Father's Name (First, Middle, Last)   19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 206 Oak St., Cambridge, MD 21613  | Town, Stala   |
| 236 Card. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition and death)   Immediate Cause (Final disease or condition resulting in death)   Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Ca | Town, Stala   |
| Sequentially list conditions, if any, leading to immediate Cause (Final disease or condition resulting in death) Last   Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of):    Due to (or as a consequence of):   |   |
| Section and colors   Section   Sec   |   |
| 2da Card. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition resulting in death)  |   |
| disease or condition resulting in death)  Due to (or as a consequence of):   Approximata<br>Interval Between<br>Onset and Death  |
Due to (or as a consequence of):    Due to (or as a consequence of):	Johons
Cause (Disease or Injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequenc	
Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  D	
Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  D	1
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1 Yes 2 No 3 F  Ather sclerotic cardio vascular Discase  24a. Was an autopsy performed?  1 Yes 2 No  1 Yes 2 No  24b.  1 Yes 2 No  1 Yes 2	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1 Yes 2 No 3 F  24a. Was an autopsy performed?  1 Yes 2 No  24b.  25. Was cese referred to medical axeminer?  Hospital:	
At Nal fibrilation  24a. Was an autopsy performed?  1   Yes 2   No    25. Was cese referred to medicel axeminer?  Hospital:   Other:   Oth	a to the cause of death?
At Nal fibrilation  24a. Was an autopsy performed?  1   Yes 2   No    25. Was cese referred to medicel axeminer?  Hospital:   Other:   Oth	Probably 4 Unknown
25. Was cese referred to medicel acrominer?  26. Place of Death (Check only one)	Were autopsy findings available prior to completion of ceuse of death?
25. Was cese referred to medicel axeminer?  Hospital:	1 ☐ Yes 2 ☐ No
The state of least the state of	ecify)
27. Menner of Death 1 Neturel 5 Pending investigation 3 Suicida 4 Homicide 28a. Date of Injury 28b. Time of Injury M 28c. Injury at Work? 1 Types 2 No 28b. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? 1 Types 2 No 28c. Injury at Work? 1 Types 2 No 28c. Digital Sec. (Specify) 28b. Describe how Injury occurred 28c. Injury at Work? 1 Types 2 No 28c. Injury at Work? 28c. Injur	
3 Suicida 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Finding City or Town, State)	ural Route Number,
29a. Certifier  (Check only one)  29a. Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s)	
29b. Signature and fille of certifier 29c. Licensa number 29d. Date signed (Mon	
D50804 12-21-3	e to the cause(s)
30. Name and address of person who completed ocuse of death (from 22a) (Type, Print)	e to the cause(s)
State Begistrar DEC 21 2000 32. Registrar's Signature parks.	e to the cause(s) th, Day, Year)

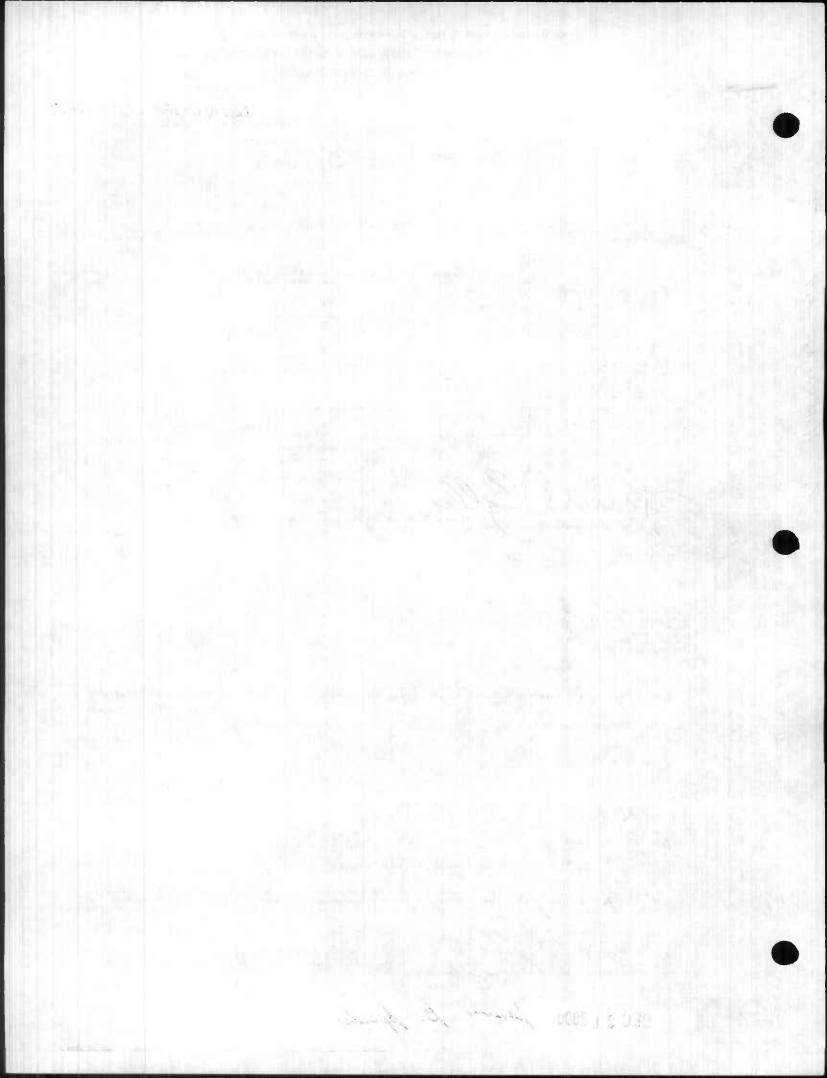


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State of Maryland / Department of Health and Mental Hygiene 10 1, 2551

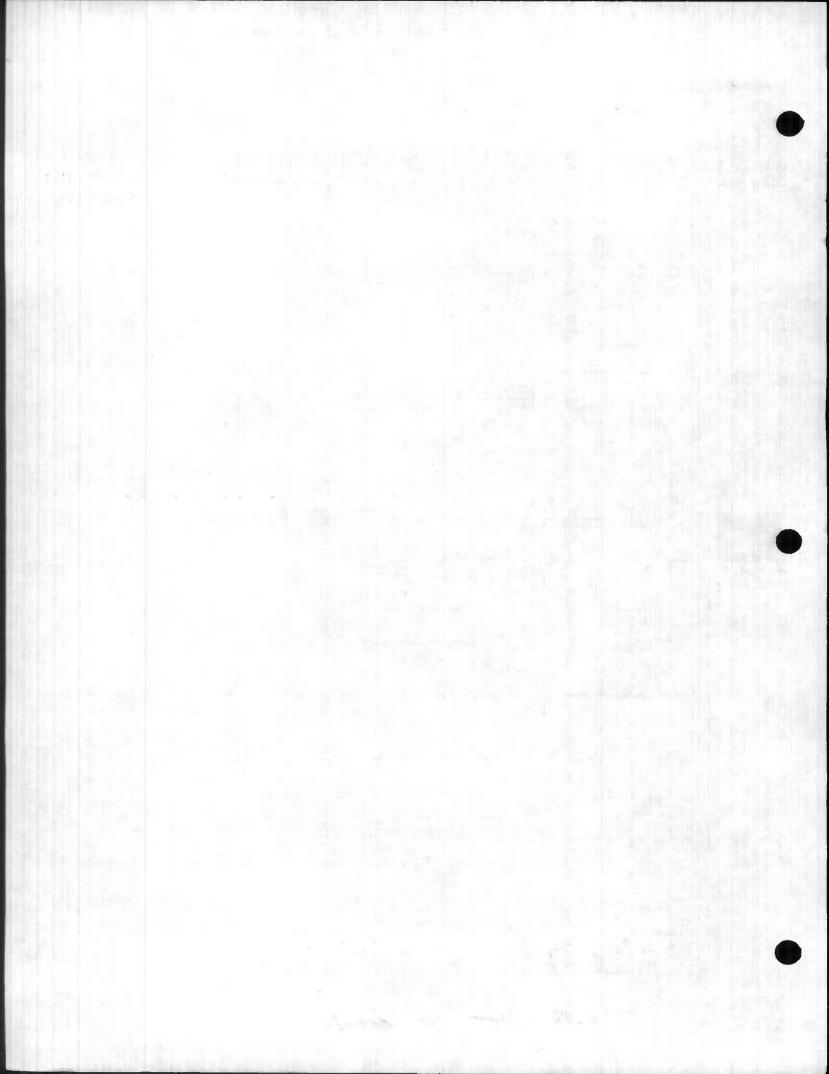
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sician									Month	Day	Year	1217
dical	RAY EUGEI			ımher)			4b	City, Town, or	Decemb		2000 ity of Death	1011
ner	The second secon		REGIONAL		CENTE	R		SALISE			ICOMI	CO
	5. Social Security I		6. Sex	7. Age (In yrs.		If Undar 1		If Under 24 Hrs				plece (Stete or Foreigntry)
	214-42-88 Usuel Residence		1ÄM 2□ F	58	Yrs.	Months	Deys	Hours Min.	SEPT.	4,1942	MARY:	LAND
	10a. Slete	10b. County		10c. Ci	ty, Town or Lo	cation			J 19 19 1		1	0d. Insida City Limit
i	MARYLAND	DORCHES	STER	CAM	BRIDGE							1 X Yes 2 □ N
-	10a. Street and Nu	ımber				10f. Zip C	ode			10g. Citlzen d	Whet Cour	ntry?
-	2416 CAN'	TERBURY	DRIVE			2161	3			USA	A	
	11. Meritel Status	-17 204	Armed F	cedent Evar in U	,S. 13. \	Wes Deceder I Yes, specify	ol His Cuban	penic Origin? (S Mexican, Puer	pecify Yes or No Rican, etc.)	0- 14. R	ece - Americ	
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	19a. Informent's N								ral Route Numi			
-	DORIS WA		L/WIFE	20h	2416 Plece of Dispo			I DKIVE:	CAMBR]	20c. Locatio		
		Cremation	3 □Removal from	State	cemetery, crer	netory or oth	er plece	1				
1	4 Donation	5 ☐ Other (Sp		BRC	OKVIEW			-4.Fa-100	12/21/0	O RKOO	KVIEW,	MARYLAND
1	21. Signaturiyer 6	MALA (	1/2 /2	selle	ZE		UNE:	RAL HOMI	E, P. O. AST NEW			1631
1	23 Pert 1/ Enter shook, or he	the diseese, or	complications thet	caused the dear								Approximete Interval Between
-	Showk, or ne	ert renure. List t	orny one couse on	emical line.							+	Onset end Death
	Immediate Cause disaase or conditi	(Finel	M	etaste	f.c.	Some.	11	C 11	0-1		1	2 mont
	resulting in death)		a		or as e consec			Ce 1	Cott C ,			
- Valley												
	Sequentially list of	onditions,	0.	Due to (	or as a conseq	juenca ol):						
	Sequentially list of any, leading to it cause. Enter Und Ceuse (Disease of that initieted event	ierlying r injury										L. Denney
	that initiated event resulting in death)	ts Last		Due lo (d	or as e conseq	uence of):						
			d.									
											1	
	Pert II. Other signi	ificant condition	ns contributing to	death but not res	sulting in the u	nderlying cau	se give	n in Pert f.				o the cause of deat
									1	Yes 2 N	o 3□Pro	bably 4 Unkno
								n-L-T-	24a, We	s en autopsy	24b. W	ere autopsy lindings
									per	lormed?	CC	vailable prior to
				_								death?
										· · · · · · · · · · · · · · · · · · ·		
					1516					Yes 2 No	) 1	☐ Yes 2☐ No
	25. Wes case refa		Hospitel:				Othe		eth (Check only	one)		
	examiner?	(No	-	Inpatient 2				4 Nursing I	eth (Check only	one)	Other (Speci	
	examiner? 1 Yes 28  27. Manner of Dee 1 Natural	(No	28a. Dete		ER/Outpatier 28b. Time of Injury		: Injury Work	4 Nursing I	eth (Check only	one)	Other (Speci	
	examiner? 1 Yes 28  27. Manner of Dee	No oth 5 ☐ Pending	28a. Determination of be 28e. Ptec	of Injury	28b. Time of Injury	M 280	: Injury Work 1   Y	4 Nursing I	eth (Check only dome 5 Res 28d. Describe	one) sidenca 6 0	Other (Speci	
	examiner?  1 Yes 28 27. Manner of Dee 1 Natural 2 Accident 3 Suicide 4 Homicide  29e. Certifier	5 Pending investig 6 Could n determi	28a. Determent of the proof of	e of Injury nth, Dey Year) se of Injury - At h ding, etc. (Speci	28b. Time of Injury	M 286	c. Injury Work 1   Y	4 Nursing I	eth (Check only tome 5 Res 28d. Describe 28l. Location City or To	one) sidenca 6 (Control of the Control of the Contr	Other (Special Coursed Special Coursed Special Coursed Special Course Special Cou	fy)  al Route Number,
	examiner?  1 Yes 28  27. Manner of Dee  1 Matural  2 Accident  3 Suicide  4 Homicide  29e. Certifier (Check only one)	No  S Pending investig  G Could n determi	28a. Detrophetion of the pend 28e. Plecholist physician: To the examiner: On the	e of Injury nth, Dey Year) se of Injury - At h ding, etc. (Speci	28b. Time of Injury	M 286 M eet, factory,	the time	4 Nursing I	eth (Check only tome 5 Res 28d. Describe 28l. Location City or To	one) sidenca 6 0 how injury occ (Street end Num, Stete) e ceuse(s) end how and pleces	Other (Special curred member or Rur menner es a la, end due l	al Route Number, steted. o the ceuse(s)
	examiner?  1 Yes 28  27. Manner of Dee  1 Matural  2 Accident  3 Suicide  4 Hornicide  29e. Certifier (Check only)	No  S Pending investig  G Could n determi	28a. Detrophetion of the pend 28e. Plecholist physician: To the examiner: On the	e of Injury  nth, Dey Year)  e of Injury - At h  ding, etc. (Speci  e best of my kno  basis of examine	28b. Time of Injury	M 286 M reet, factory, on occurred et vestigation, in	the time	4 Nursing I at res 2 No o, date end plecenion, deeth occur	eth (Check only tome 5 Res 28d. Describe 28l. Location City or To	one) sidenca 6 (a) how injury occ (Street end Nu wm, State) e ceuse(s) end d, date end plec	Other (Special curred member or Run menner es ea, end due to med (Month,	al Route Number, steted. to the ceuse(s)  Dey, Year)
	examiner?  1 Yes 28  27. Manner of Dee  1 Matural  2 Accident  3 Suicide  4 Homicide  29e. Certifier (Check only one)	No  S Pending investig  G Could n determi	28a. Detrophetion of the pend 28e. Plecholist physician: To the examiner: On the	e of Injury  nth, Dey Year)  e of Injury - At h  ding, etc. (Speci  e best of my kno  basis of examine	28b. Time of Injury	M 286 M reet, factory, on occurred et vestigation, in	the time	4 Nursing I	eth (Check only tome 5 Res 28d. Describe 28l. Location City or To	one) sidenca 6 0 how injury occ (Street end Num, Stete) e ceuse(s) end how and pleces	Other (Special curred member or Run menner es ea, end due to med (Month,	al Route Number, steted. to the ceuse(s)  Dey, Year)
Medical Certification: To Be Completed by	examiner?  1 Yes 28  27. Manner of Dee  1 Matural  2 Accident  3 Suicide  4 Homicide  29e. Certifier (Check only one)	No bith 5   Pending investig 6   Could n determi 1   Certifying 2   Medical E	28a. Determed 28a. Pter (Mo etion of be need 28a. The built grant of the complete of the compl	e of Injury nth, Dey Year)  re of Injury - At he ding, etc. (Special special s	28b. Time of Injury  some, Ierm, str  fy)  owledge, deeth stion and/or in	M 286 M eet, factory,	the time	4 Nursing I at ) es 2 No  o, date end plecenion, deeth occurrent	eth (Check only tome 5 Res 28d. Describe 28l. Location City or To	one) sidenca 6 (a) how injury occ (Street and Numer, State) e ceuse(s) and to date and plec 29d. Date sig	Dither (Special Coursed Coursed Coursed Coursed Coursed Coursed Course)  menner es a ca, end due to course (Month, 19, 2)	al Route Number, stelled. to the ceuse(s)  Dey, Year)

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			Cei	rtificate c	f Death	7	Re	g. No.		
	1. Decedent'a Nama (First, Middle, Las	)	5 4 84				2. Date of Death		V	3. Time of Death
Physician	Charles Joseph	Warren, Jr.					Month Decembe	r 13	2000	10:10AM
/Medical Examiner	4a Facility Nama (If not institution, giva		1000	V = 10	4b. City, To	own, or Lo	cation of Death	4c. County	of Death	
LAUITHICI	Holy Cross Hosp	ital			Silv	er Sp	oring	Mon	ntgom	ery
Funeral	5. Social Security Number 6. Se		lest birthday)	If Under 1 Ye	ar If Unde	r 24 Hrs.				ace (State or Foreign
Director	577-44-4634	2M 2□F 6	7 Yrs.	Months Da	ys Hours	Min.	8. Date of Birth (Month, Day, Aug. 2,	1933	Was]	h., D.C.
_	Usual Rasidence of Decedent									
show at at	10e. State 10b. County	10c. Cit	y, Town or Lo	ocation					10	d. Inside City Limits
northed at rector	Maryland Prince (	George's		Land	over					1. Yes 2 □ No
Director	10e. Street and Number			10f. Zip Cod			10	g. Citizen of V	Vhat Count	ry?
	3203 Amador Driv	'e			20785			Unite	ed Sta	ates
funeral	11. Marital Status	12. Was Decedent Ever in U	S. 13.	Was Decedent	of Hispanic Or	rigin? (Spe	ecify Yea or No- Rican, etc.)		e - Americe	
F F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No					Rican, etc.)	Blac	k, Whita, e	etc.
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 1	No Specify	<i>'</i> :		Specify	: B1	ack
	15. Decedent's Edu	cation	16a. Dece	dent's Usual Oc	cupation		1	6b. Kind of Bu	usiness/Ind	ustry
Completed	(Specify only highast grad	le completed)	(Give	dent's Usual Oc kind of work do DO NOT use re	ne during mo: lired)	st of worki	ng	Supply	7 & Se	ervices
E O	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		Dire				* * *		efense
U	17. Fathar'a Name (First, Middle, Last)		1			ner's Nama	(First, Middle, M	•		
traumatic avent, To Be C	Charles Joseph	Warren			1000	Ac	la Willi	ams		
5	19a. Informant's Name/Relationship (T)		19h Maili	ng Address (Str	set and Numb	her or Rure	I Route Number,	City or Town	State Zin	Code)
	Charles J. Warre						lover, M		0785	
	20a. Method of Disposition			sition (Neme of		1		Oc. Location -	City or Tox	wn. Stata
	N Burial 2 ☐ Cremation 3 ☐	Removal from State	ematery, crai	metory or other	plece)	1.0				
DDCs.	4 Donetion 5 Other (Specify,			coln Ce			2/16/200			
Suce	21. Signature of Funeral Service Licens	00 A		2. Nama and Ad		*	Stewart			
5	1 skin to Sh	111 1/10/21	_	4001 Be	nning	Rd.,	N.E. Wa	sh., D.	.C. 20	3019
	23a. Part. Enter the disease, or composhoc or heart failure. List only of	lications that coused the deat	h. Do not ent	ter the mode of	dying, such as	s cardiac o	or respiratory erre	st,		Approximate Interval Between
n	or realt failure. List only o	no cause on each line.							1	Onset and Deeth
al	Immediate Cause (Final	Proumonic								
er	disease or condition resulting in death)	Pneumonia	or as a consec	auonco of):			_		1	
<u>ē</u>		Bilateral			cion				1	
Ē	Commendative time and distance	b	ras a consec		.51011				1	
Exa	if any, leading to immediate	Renal Fai		4001100 017.						
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	r as a conseq	wasaa afti				200		
ledical Examir	rasulting in death) Last	D00 t0 (0	as a conseq	(uence or).						
2		d. Multiple	Skin U	llcer						
20							1			
Physician/	Part II. Other significant conditions co		ulting in the u	nderlying ceuse	given in Part	1.				the cause of death
	Diabetes M	lellitus					1 🗆 Ye	8 2 ₹ No	3 Prob	ably 4 Unknov
leted by P							Ode Week	autonou	24h We	re eutopsy findings
Completed							24a. Was ar perform	ned?	ava	nilable prior to
Be Comple										death?
Ö							1 ☐ Ye	s 2 No	1 🗆	Yes 2□ No
Be	25. Was case referred to medical examiner?				26. Plac	ce of Death	(Check only one	9)		
0	1 Yes 27 No	Hospitel: 1 Nnpatient 2	ER/Outpatier	nt 3 DOA	Other: 4 N	lursing Ho	me 5 Reside	nce 6 Oth	er (Specify	)
	27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time o Injury	28c. l	njury at Nork?		28d. Describe ho	w injury occur	red	
atic	1 Natural 5 Pending 2 Accident investigation				Yes 2	]No				
Certification:	3 Suicida 6 Could not be determined	28e. Place of Injury - At his building, etc. (Specif	ome, farm, st	reet, factory, off	се		28f. Locetion (Str City or Town	eet and Numt	er or Rure	Route Number,
le l		building, etc. (Specif	y)				Only or Your	, 0.0.0)		
	29a. Certifier Certifying Phy	sician: To the best of my kno	wledge, deat	h occurred et the	time, date a	nd place, e	end due to the ca	use(s) and ma	nner as st	ated.
edicai		ner: On the besis of examina and manner stated.								
N N	29b. Signature and title of certifier	1		29c. Lic	ense number		29	d. Date signe	d (Month, L	Day, Year)
	1 de de	1.6		0	5045	4	6	)0		15
7	D81	W-			, , ,	/	U.	Can	eise	7,13,20
/	30. Name and address of person who o									
	Arastoo Yazda			orgia A	ve., S	ilve	r Spring	, MD	2090	2
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	1						
etrar	[1]-1' 1 X / [1][]	12000	1.9							

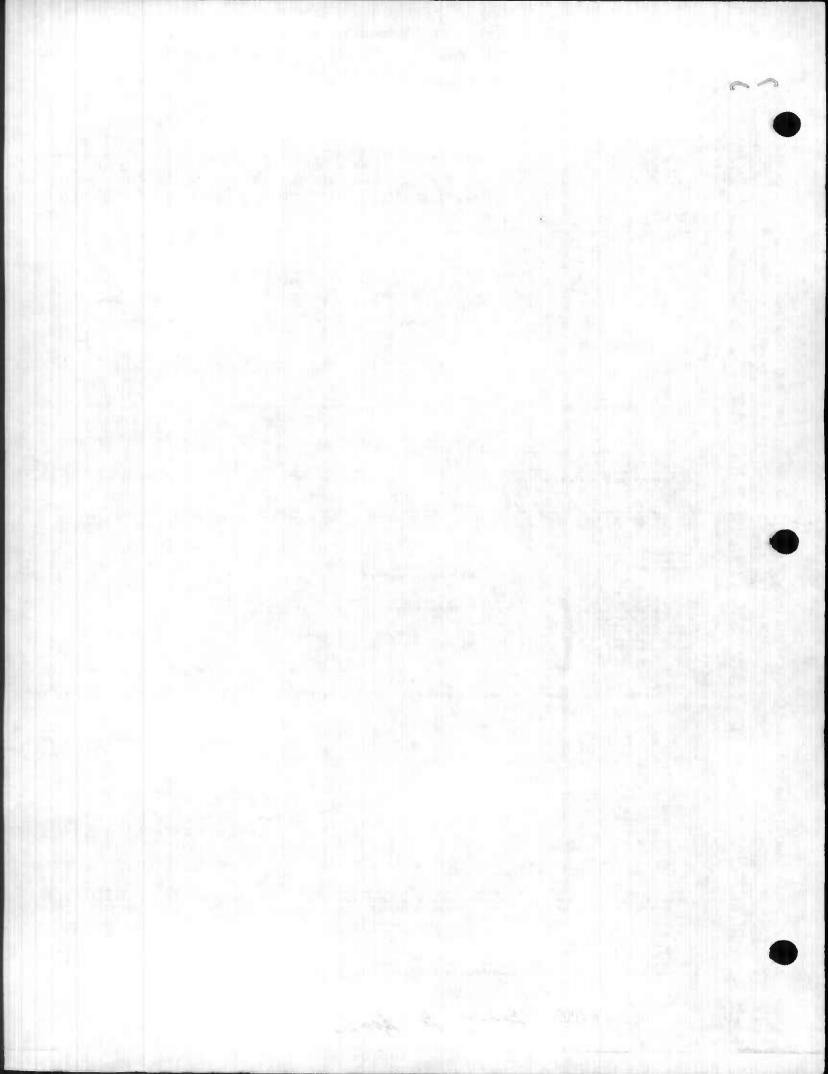


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State of Maryland / Department of Health and Mental Hygiene

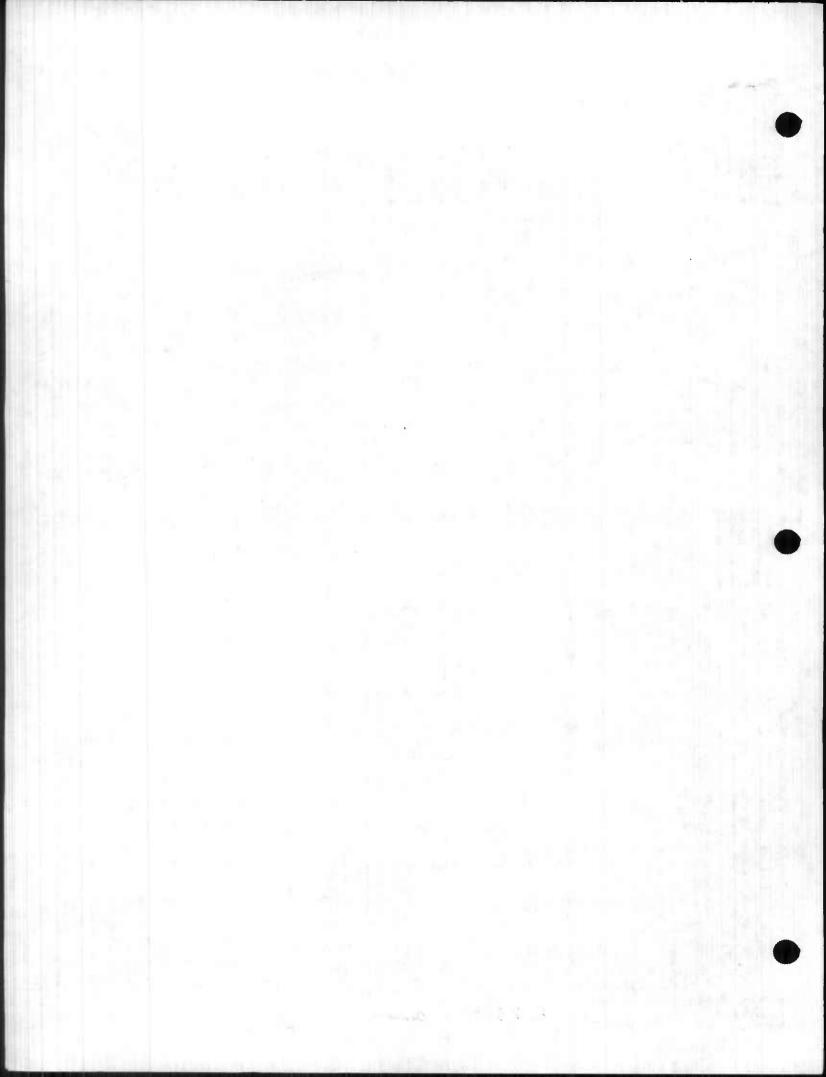
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7	6 .	V	6.	1

			Ce	rtificate	of Death		Reg. No.		
	1. Decedent's Nama (First, Middla, Las	st)				2. Data of D	eath	44	Time of Death
Physician	raillite wright					Decemb	er 12,	2000 10	):50
/Medical Examiner	40 Facility blome /// and institution of	street and number)			4b. City, Town, o	or Location of Deal	h 4c. County	of Death	
LAdminer	Heartland Health	Care Cente	r-Adelph	i	Adelpl	hi	Pri	nce Geo	raes
Euparal	5. Social Security Number 6. S		yrs. lest birthday)	If Under 1	Year If Under 24 H	rs. 8 Date of Bi	rth		(State or Foreign
Funeral Director		□M 2\ F 96		Months	Days Hours Mi	n. (Month, D	9, Year) 1904	Country)	ring V
Birector	Usual Residence of Decedent					puly 1	, 1904	J.auesp.	Ling, V
a Bu	10a. State 10b. County	10	c. City, Town or Lo	ocation		154.000		10d. lr	side City Limits
Vany	MD Prince G	eorge's Hy	attsvill	.e				1)	Yes 2 No
or 28a-f shorte be notified at Director	10e. Street and Number			10f. Zip C	nde		10g. Citizen of \	What Country?	
		100						, mot oountry .	
5 2 5	5441 16th Ave. Ap		1110	20782			J.S.A.	a. Amadasa ta	dian
Hems her cha	11. Marital Status	12. Was Decedant Eva Armed Forces?		If Yes, specify	nt of Hispanic Origin? r Cuban, Mexican, Pu	(Specify Yes or N arto Rican, etc.)		e - Amarican în ck, White, etc.	dian,
9 % M M	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1 □ Yes 2)	No Specify:		Specifi	Black	
mal, o		Year or Dates:							
ad within 72 ho tygione. ser than "natur it, the Medical.	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual	Occupation done during most of w	vorkina	16b. Kind of B	usiness/Industry	
min min	Elementery/Secondery (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)		Private		
white and	3rd		Housev	vife					
The state	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle	, Meiden Sumen	na)	
Menta Menta sirked site en	Lee Smith				Maude N	layhan			
of Bull	19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ing Address (	Street end Number or	Rurel Route Numb	er, City or Town,	Stete, Zip Code	9)
	Tyrone Wright/So	n	5441	16th A	ve. Apt. 1	102 Hyatt	sville,	MD 207	82
Ten Ten	20a. Method of Disposition	2	20b. Place of Dispo	osition (Neme	ol	Date	20c. Location	City or Town, S	Stata
mit. Pages 1 a partment of Hea portant. If them? y injury or othe	1 Burial 2 Cremation 3	Removal from State	cemetery, cre	matory or oth	ar plece)	12/16/00	Brentwo	d MD	
4 4 4 5	4 Donation 5 Other (Specifi					1			
He soul	21, Signature of Funeral Service Licen	Aee )			Addrass of Facility				е
20249	1 Buch B	Auch _		7474 La	indover Rd.	Landove	er, MD 2	0785	
	23a. Part1. Enter the diseasa, or companies shock, or heart feilure. List only	plications that caused the	death. Do not en	ter the moda	of dying, such as card	iac or respiratory	arrest,	App	roximate val Between
Examiner	resulting in death)	Myocardia Du	to (or as a conse					13	
outed ansi	Sequentially list conditions		to (or as a conse	quence of):					
e e e e e e e e e e e e e e e e e e e	Sequentially list conditions, it any, leading to immadiate ceuse. Enter Underlying Cause (Disease or Injury								
ertificate be executed fing physician and as the burial-transit	Cause (Disease or Injury that initiated evants	C. Dua	to (or as a consec	nuence of):	12 7 1				
g phys as the	resulting in death) Last								
n cent		d							
death certific at the standing ped for use as						l est mi	A DE COLO		
the character and the	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	inderlying ceu	se given in Part I.		tobacco uae co		V
that the ed by the detache	Dementia					1	Yss 2 No	3 Probably	4 Unknow
9 5 8				1-1-				T 045 Week	Annual Codings
v requires been sign should be	Atrial Fibrillat	ion				24a. Wa per	s an autopsy ormed?	availabl	utopsy findings a prior to tion of causa
has by ge 2 st						-		of deeth	1?
The Lange page						10	Yes X No	1 □ Yes	2 No
certificate rector, pag					26. Place of D	Deeth (Check only	one)		
Physician: this certific ral director,	examiner?	Hospital:	2 ER/Outpetie	nt 3 DOA		Home 5□ Res		ner (Snecity)	
£ £ 5		28a. Date of Injury (Month, Dey Ye			: Injury at Work?		how injury occur		
Afte fund	1 Neturel 5 Pending investigation		ear) Injury	М	Work? 1 ☐ Yes 2 ☐ No	1			
tal or Attending P is after death. al Director: After t led in by the funer Certification:	2 Accident Investigation 3 Suicide 6 Could not be		At home farm st	reet factory		28f. Location	(Street and Num	ber or Rurel Ro	ite Number.
or Attending after death. Director: After Jin by the fune	4 Homicide determined	building, etc. (5	Specify)	loot, laotory,	511100		wn, Stete)		
illed C									
he Hospital in 24 hours he Funeral pletely filled	29a. Certifier Certifying Ph (Check only 2 Medicat Exam	ysician: To the best of mainer: On the basis of exa	amination and/or in						
7.570		and manner stated							
To the Com	29b. Signature and title of continer	3			icansa number		29d. Data signe		Year)
	1 LATO			D42	2749		12/15/	2000	
(1)	30. Name and address of person who	completed ceuse of death	(Item 23a) (Type	Print)					
(2)					101				
	Dr. Raymond Nwadi 31. Date filed (Month, Dey, Year)	uko 9831 Gr	eenbelt l	Kd. Su	re 101 Lai	nham, MD	21029		
State	DEC 1.8 2000	Zanagistral s	Cignature	-					



WillZerson

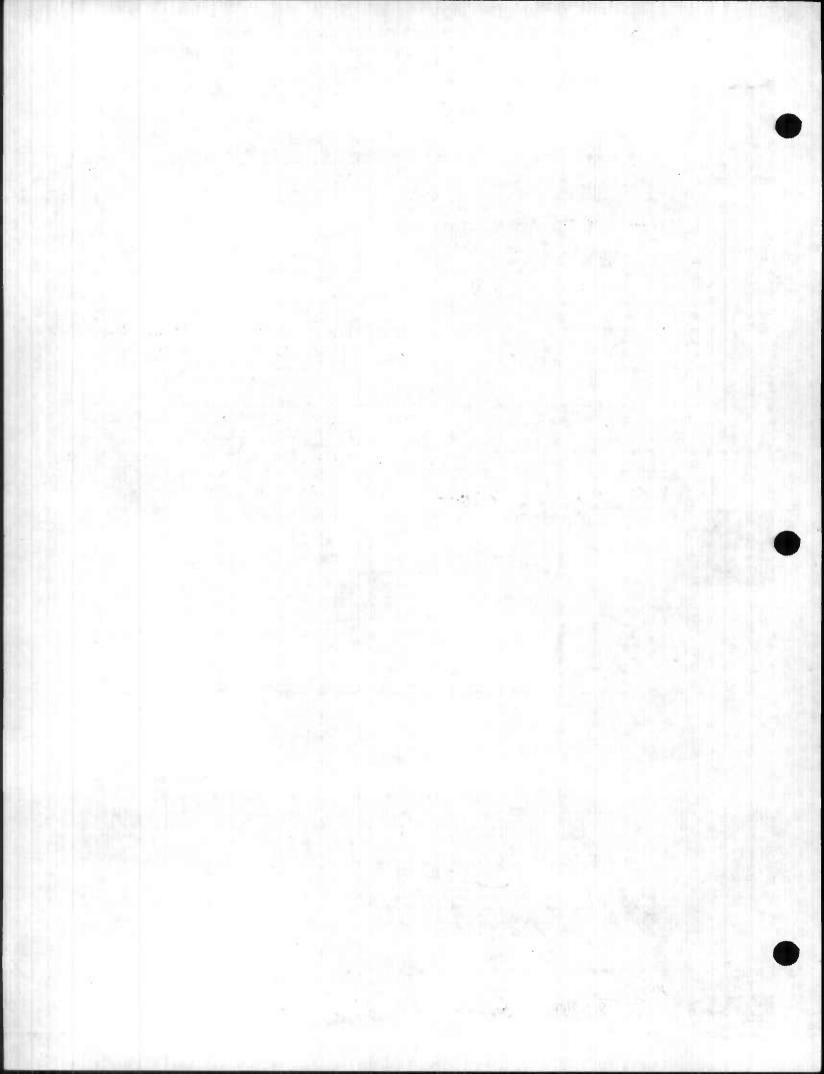
	GC 12-20- 1. Decedent'a Ne		, Last)		100	Cortin	0410 01	f Death	2. Date of D		Vees	3. Time of Deeth
cian lical	CC	DLEY WIL	KERSON						DECEMB:	ER 16,20	00	7:48am
ner	4a Facility Neme	(If not institution	give street end	d number)				4b. City, Town, or	Location of Dea		of Deeth	• • •
	Washing 5. Sociel Security	Ston Adv	entist 6.Sex		tal (In yrs. lest bii	rthdev) If U	Under 1 Yea	Takoma Par If Under 24 Hrs	ark 8. Dete of Bi		0	lece (State or Fore
	248-46-5		1₹M 2□		70	Yrs. Mo	onths Dey			23, 1929	Cour	h Caroli
	Usuel Residence 10a. Stete	of Decedent			10c. City, Tow	m or Locatio						0d. Inside City Lim
	Md.		e Georg	66		svill					1	1 Yes 2□
	10e. Street and N		e deorg	<b>C</b> 3	nyacı		Of. Zip Code		0 3	10g. Citizen of V	Whet Cour	ntry?
	2708 Kir	ckwood P	1200 #1	0/1			2078	8.2		U.S.	٨	
	11. Marifel Status		12. Wes I	Decedent E d Forces?	Ever in U,S.	13. Was I		Hispenic Origin? (Suben, Mexican, Puer	Specify Yes or N to Rican, etc.)			can Indien,
		rried 2 Merri	ed 1 Yes	es 2 N	lo		Yes 2 N			Specify		
	3 Li Widowed	4 Divorced		or Detes:	16a	Decedant's	s Usuel Occ	upetion		16b. Kind of Bu		
		ecify only highes	t grade complet	ted) ge (1-4or 5-	,)	(Give kind life. DO N	of work don IOT use reti	upetion e during most of wo red)	rking			
	Elamentary/Sec 12th	condery (0-12)	Collec	ge (1-401 3-	+)	Mecha	nic			Priva	ate	
	17. Fether's Nemo	e (First, Middle, I	ast)					18. Mothar's Nei	me (First, Middle	e, Maiden Sumem	10)	
	Unknown	I DE B						Unknow				
	19e. Informant's							et end Number or Ri				
	Joyce Wi		wile		20b. Place o	d Disposition	n (Neme of	od P1 #10	Date	20c. Location		
	1 Buriel	2 Cremation 5 Other (Sp		rom Stata		ry, cremator			2/22/00	T '	N	£.3
	21. Signeture of I				нагто				2/23/00 ohnson (	Landove Jenkins		
	1 /5	che.	1.1	end	V	716						
				20101	3	/16	Kenne	dy St., N	.w. wasi	1. D. C.	20011	
her	23a. Pert1. Enter shock, or he Immediate Ceuse disease or condit resulting in deeth	e (Finel	ediplications the	Lar	the deeth. Do le.	not entar the	a mode of d	dy St., N ying, such es cerdia			20011	Approximete Interval Batween
	Immediate Ceuse	e (Finel tion i) conditions, immediate derlying or injury nts	e	Lar	ing	consequence	a mode of d	- ,				Approximete Interval Batween
	Immediate Ceusidiseese or condit resulting in deeth Sequentielly list of any, leading to causa. Entar Unicause (Disaasa othet initieted ever	e (Finel tion i) conditions, immediate derlying or injury nts	e	Lar	Due to (or as e	consequence	a mode of d	- ,				Approximete
	Immediate Ceusidiseese or condit resulting in deeth Sequentielly list of any, leading to causa. Entar Unicause (Disaasa othet initieted ever	e (Finel tition n) conditions, immediate derlying or injury nts nts	ė( b c	Lar	Due to (or es e	consequence	a mode of d ce of): ca of):	ying, such es cerdia	c or respiretory	d tobacco use co	ntribute t	Approximete Interval Batween Onset and Deeth
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State of Maryland / Department of Health and Mental Hygiene

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10d. Inside City Limits 1 ☐ Yes 2 ☐ No

White

Approximata Interval Between Onset and Death

Type or Print In Black Indelible State of Maryland / Departmen							
Certificat	e of Death	Reg. No.					
st)		2. Data of Death Month Day	Year	3. Time of Death			
lus Williams		December 1	7,2000	11:00AM			
e street and number)	4b. City, Town, or	Location of Death 4c.	County of Death				

**Funeral** Director

**Physician** 

/Medical

Examiner

Directo Funeral by Completed

John II. Pages 1 and 2 should be filed within 72 hours after death with the Maryland opportunit of Health and Mantel Hygiene. Important: If item 27 is marked other than "naturals, or items 23a or 28a-f show any Injury or other treumatic event, the Medical Eventment must be notified at 80cs.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

attending physician and for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 ed by the a been signed by should be detac this certificate has ral director, page 2 or Attending Physicien: funeral After t after deeth. Funeral Director: / 24 hours

Be Physician/Medical Examiner Completed by Be 10 Certification: Medical

1. Decedent's Nama (First, Middle, La Julian Marcel 4a Facility Name (If not institution, giv Clinton

If Undar 24 Hrs.

Min.

8. Data of Birth
(Month, Day Ye Prince George's Southern Maryland Hospital Center If Under 1 Yaar Birthplaca (State or Foreign Country) Age (In yrs. last birthday) Days 10M 20 F Months 77 Yrs. Washington DC 578-09-8207 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. Counts Fort Washington Maryland Prince George's 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8309 Bernard Drive 20744 U.S.A. 12. Was Decedent Ever in U.S. Amped Forcas? ∠MYas 2 □ No WWII If Yes, Giva Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc. 1 Naver Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) N/A Insurance Company Insurance Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) John C. Williams Julia Ann Willey 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8309 Bernard Drive Ft. Washington, MD 20744 Helen T. Williams (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) December Date 1, 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from Stata Resurrection Cemetery 2000 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funaral Service Lisense 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Part 1. Enter the diseasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in deeth) NON Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Last Due to (or as a consequence Due to (or as a consequence ot)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 2 A 1 Yes 2 No

23b. Did tobacco use contribute to the cause of death?

25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Day Year) 27. Menner of Death 1 Menurel 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature and title of certifiar

29c. License number

29d. Date signed (Month, Day, Year)

MOTI KOUL MED

2000

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

Moti Koul. M.D. 4467 Old Branch Ave, Suite 203, Temple Hills, MD 20748

Registrar

VA

31. Date filed (Month, Day, Year)
DEC 2 0 2000

32. Registrar's Signature outs a my the sale of the sale of the ا عربيد إن الماليات . المسيماليات والهز عليه ... و E SHIP GALLON TOOK JUNEAU

State of Maryland / Department of Health and Mental Hygiene 1 4 2 5 5 7

	Physici		1 Decedent's Name (First Mid												
	/Medi		1. Decedent's Neme (First, Middle, Last)  LEO T WARREN  4a. Fecility Name (If not institution, give street end number)  4b. City, 7									2. Dete of De Month 12	20 Dey	2000	3. Time of Deeth 9;40AM
1	Examir	ner	4a. Fecility Name (If not institute MARINER HEA			ER SPR	ING	G,Md.				ocation of Deeth		Inty of Deeth	ERY, COUNT
	Funeral Director		5. Social Security Number 578-03-9596  Usuel Residence of Decadent	6. Sex XXX M 2□ F	7. Age	(In yrs. last birth	rs.	ff Under 1 Y Months D	eys	If Under Hours	24 Hrs. Min.	8. Dete of Bir Month, Da	† 90°9	9. Bint CHAI MARY	nplece (State or Foreign unity) RLES COUN' LAND
Maryland	-f show fled at	tor	10a. State 10b. Coun	GOMERY		10c. City, Town			3,	MD.					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
th the	or 28	Director	10e. Street end Number					10f. Zip Co	de				10g. Citizen	of Whet Cou	untry?
th wi	230 unit b		901-ARCOLA	AVE., SIL	VER	SPRIN	3	2090	)6				U.S.		
5-0020 72 hours after death with the Maryland	"naturel", or items 23e or 28e-f show adical Exactions must be notified at	by Funeral	11. Maritel Status  1 □ Never Merried 2 ☒ Ma 3 □ Widowed 4 □ Divorce	If Yes G	orces?			as Decedent Yes, specify				ecify Yes or No Rican, etc.)		Raca - Amer Bleck, White ecity: BL	o, etc.
5-0	n netur Medical	ted	15. Decede	ent's Education est grede completed,	)	16a. I	Decede	ent's Usual O	ccupa	ation	ion pring most of working			f Business/I	ndustry
2121 d within	r than	Completed	Elementery/Secondary (0-12) 3rd GRADE			)	life. Do	STRUC	etirea	)	I DI WOIN	any	CAFRITZ BUILDER		BUILDERS
5 8 3	⊕ O ≥	Be	17. Fether's Name (First, Middle	e, Last)						18. Moth	er's Nam	e (First, Middle,	Maiden Sun	neme)	
aryla should	Ment	P		ETT WARI	)	19b. Melling Address (Street end Number of						RACE		WARRI	
Ma	n end Mer 7 is marke traumatic		19a. informent's Neme/Relation												ip Code)
	ft. Peges 1 and running them 2 njury or other		ROSIE SHORT	, AUNT		P.O. BOX				30 L.	APLA	Date Date		046 on - City or T	Four State
0 8 7			XXBuriel 2 Cremation 4 Donetion 5 Other	Specify)	State	Z-BCHU!	RCH	etory or other	r plac ET I	ERY		12-23-			
E Ball	Impor any Ir		21. Signeture of Funeral Service	Monto.	me	4 879		Neme end A			T. A	RONE ON.W.	J. YO		
/M	ysician ledical aminer	ı,	23a. Pert1. Enter the disease, shock, or heart feilure. List immediate Ceuse (Finel disease or condition resulting in death)	e	PA	UEUM	OK	LIM	dyin	g, such es	cardiac	or respiretory e	rest,		Approximate Intervel Between Onset end Death
OX 58/50, certificate be executed	nding physiclan end use es the bunel-trensit	n/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest	b c		ue to (or es e co									
n te	e ette	icia	Pert II. Other significant condit	ione contributing to d	leath hut	not resulting in	he und	forlying cause	o aive	on In Port i		23h Did t	obacco uee	contribute	to the cause of death?
r in in	igned by the etter be deteched for u	by Physicia		norre		. 1	,	/ caus	e give	en in reiti				-	obably 4 Unknown
VICAL RECORDS,	s been s 2 should	Completed b			/								en eutopsy med?	6.0	Vere sutopsy findings vellable prior to ompletion of cause I deeth?
E e	pa de	Cou										1 U Y	es 2 N	1	☐ Yes 2☐ No
clen:	is certificate director, pay	Be	25. Wes case referred to medic examiner?						011		of Deet	h (Check only o	ne)		
P P	0 0	ion: To	1 Yes 2 No  27. Menner of Deeth 1 Naturel 5 Pendi	ng 28e. Dete	Inpatient of injury oth, Dey 1	28b. Ti		28c.		et (?		ome 5 Residence 128d. Describe 1			ify)
DIVISION Lal or Attending		Certification:	3 Suicide 6 Could	mined 286, Plece	a of Injury ing, etc.	/ - At home, ferr (Specify)	n, stree			fes 2□		28f. Location (S City or Tou	Street end Nu n, Stete)	mber or Rui	ral Route Number,
To the Hospital or / within 24 hours effer	Jetely filk	edical (	29a. Certifier (Check only one) 1 ☐ Certifyi 2 ☐ Medica	ng Physician: To the bei Examiner: On the being end man	best of e	xeminetion end/	death o	occurred et the stigetion, in r	e tim	e, dete en pinion, dee	d plece, th occurr	end due to the dred et the time, d	cause(s) end dete end plac	menner es ca, end due l	stated. to the ceuse(s)
To th	Toth	-	29b. Signeture end title of certific	er //	1	-		29c. Lic	ense	number			29d. Date sig	ned (Month,	, Day, Year)
0			· Wall	Koper	race	en, M	D.	De	09	8.39	/		12/	21/0	0
16	7/		30. Name and address of person	who completed caus	se of dee	th (Item 23e) (T	ype, Pr	rint)	1	1200	- 1/	-		2 11	1020895
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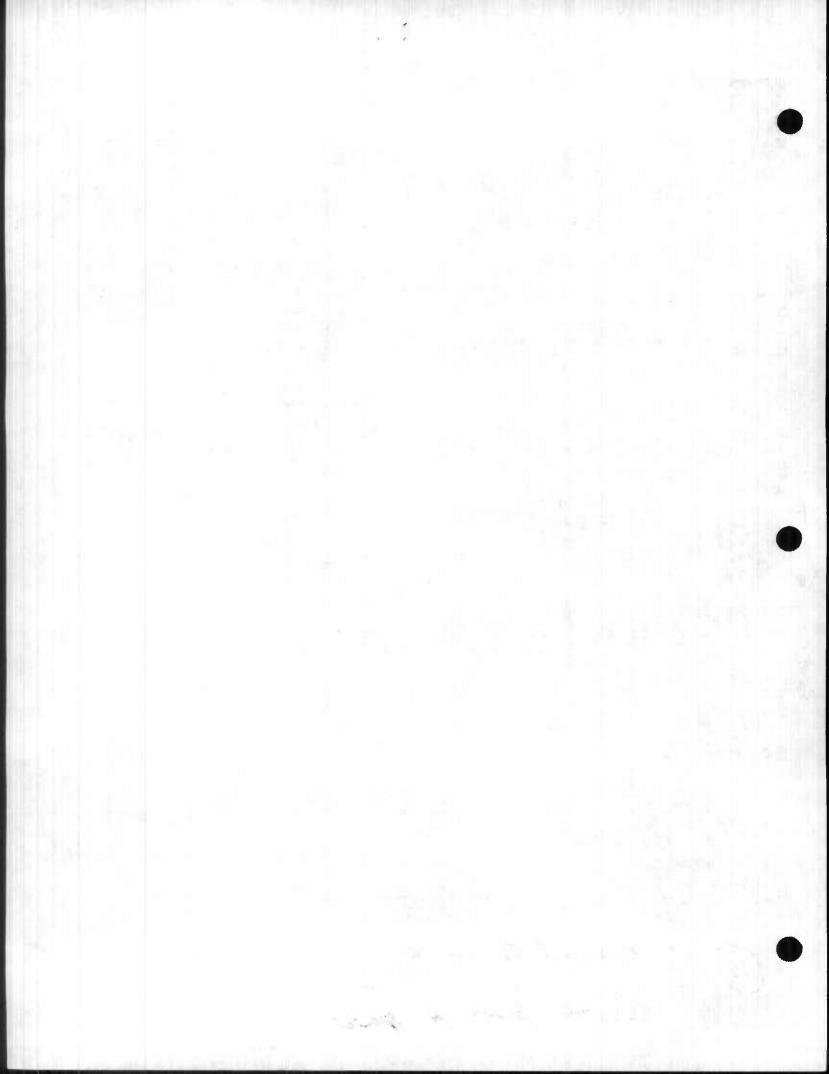
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State of Maryland / Department of Health and Mental Hygiene

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			Cen	tificate of i	Death		Reg. No.			
	1. Decedent's Neme (First, Middle, L	est)				2. Data of De		Year	3. Tima of Deatl	
Physician	Elliotte John	Uillia				Month	Dey 7 200		. 10 DM	
/Medical	Elliotte John: 4a Facility Nama (If not institution, gi		ns		b. City, Town, or L	December			5:10 PM	
Examiner	4a Pacinty Ivania (ii noi institution, gi	va sireer and number)								
	7505 Greer Drive			F	ort Washi	ngton	Prince	Georg	ges	
Funeral	5. Social Security Number 6.	Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, Da	th y, Year)	9. Birthple	ce (Stete or Fore	
Director	074-16-2530	1⊠M 2□F 79	Yrs.					_	Carolin	
	Usuel Residence of Decedent									
show den	10a. Stete 10b. County	10c. C	ity, Town or Loc	eation				10	d. Inside City Lin	
To o	M 1 1 D .	0 5.	77 1 .	100					1 Yes 2□	
28a-f shonouffied at	Maryland Prince	Georges   Ft	. Washi	10f. Zip Code			10g. Citizen of V	What Countr	ν?	
0 2 0								VII. 0001111	,	
23.8	7505 Greer Drive			2074	44		USA			
r hems 234 Inner must Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forcas?	J,S. 13. W	Vas Specify Cube	ispenic Origin? (Sp on, Mexican, Puerto	Bican etc.)	es or No- etc.) 14. Race - Amarican Indian, Black, Whita, atc.			
	1 Never Merried 2 Merried	1 X Yes 2 □ No		V		, , , , , , , , ,	All the second s			
	3 ₩ Widowed 4 Divorced	if Yes, Give Yeer or Dates:	1	□Yas 2 <sup>th</sup> No	Specify:		Specify	ck		
	15. Decedent's E	ducetion	16e Decede	ent's Usuel Occup	ation		16b. KInd of Business/Industr			
ygiene. Nor than "natur It, the Medical Completed	(Specify only highest g	rade complated)	(Give k	kind of work done	during most of work	rking				
iene.	Elementery/Secondary (0-12)	College (1-4or 5+)	_	rtment of		Military				
S T O		4	- opa	- United to						
ind Mental Hygie I marked other t umatic avant, in To Be Co	17. Fether's Name (First, Middle, Las	1)			18. Mother's Nam	e (First, Middle,	Meiden Sumem	10)		
In and Mental Hyg 7 is marked othe traumatic avant, To Be C	Henry Williams				Georgia	Garre	tt			
a mar aumet	19e. Informent's Neme/Reletionship	(Type, Print)	19b. Mailine	g Address (Street				Stete, Zip (	Code)	
w ''e e	Michael Williams			Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code)						
fram 27 other tr					s item 10 on (Name of Dete 20c. Location - City or Town, Stata					
or of	20a. Method of Disposition 1X Buriel 2 ☐ Cremetion 3	Domewal from State		etory or other plea		Dete				
5 # 5	4 Donetion 5 Other (Spec		ington	National	Cemtery	12/26/0	O Arlin	gton,	Virgin	
Department of Important: If any injury or once.	21. Signeture of uneral Selvice Lice	prisog	ss of Fecility							
Departm importar any inju	· OLIPP	ha			Kalas Fur	eral Ho	me PA			
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n and val-transit Examiner	Sequentially list conditions	Prostate C	or es e consequ ANCET or es e consequ							
	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	Hypertensi	on							
ding physicises as the bu	resulting in death) Last	Non-Insuli	n Depen	dent Dia	betes					
d by the attentional set of the s	Part ii. Other significant conditions	contributing to death but not re-	sulting in the un	derlying cause giv	an in Pert I.	23b. Did	tobacco use co	ntributa to	the cause of de	
Value 4	D T	D.				1 🗆	Yee 2 No	3 Prob	ably 4 Unk	
d be de	Degenerative Jo	int Disease								
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nactor, pa	25. Wes case referred to medicel examiner?				26. Plece of Dee	th (Check only	one)			
	examiner/ 1 ☐ Yes 2 ☑ VNo	Hospitel: 1 Inpatient 2	ER/Outpetient	3□ DOA Oth	er: 4 Nursing H	ome 5 Resi	dence 6 □Oth	er (Specify	)	
	27. Menner of Death	28e. Dete of Injury (Month, Dey Year)	28b. Time of	28c. Injur Wor			how injury occur			
To the	1 Neturel 5 ☐ Pending 2 ☐ Accident Investigetic		Injury		k? Yes 2 □ No					
al Director: After to do in by the funeral certification:	3 Suicide 6 Could not	be 200 Place of Initial At I	nome form eter			28f Location /	Street and Numb	per or Rural	Route Number	
in by	4 ☐ Homicide determine	building, etc. (Spec	ify)	ot, ractory, omce		City or To	wn, Steta)	. J. J. (1010)		
Med P										
dies		hysician: To the best of my kn iminer: On the basis of exemin and mannar stated.								
To the comple	29b. Signatura and title of certifiar			29c. Licens	e number		29d. Data signe	d (Month, E	Dey, Year)	
1 0	1/2	0 8		D0031	17		12/08/20	000		
( )	- Mure a	R. Ofermone	Ma	100031	. /		12/00/20	000		
101	30. Neme and address of person who	completed cause of deeth (Ite	m 23e) (Type, F	Print)						
1	Dr. Karenga R. L	emmone MD 610	4 014 R	ranch A.	anua Toma	10 H:11	c MD	20.	748	
01	31. Dete filed (Month, Dey, Year)	Registrer's Sign		Tanch AV	ande remi	ne mil	اللاز و	40	40	
State	DEC 1 2 2000	haran Sign		band.						
Registrar	DEO 15 5000	1	A. A.	AR NO						



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITIEM: 29D PER VERBAL RESPONSE SS. Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Death Day 15 **Physician** Month 12 Theodore Victor Wilson 2000 7:55PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dennett Road Manor Nursing Home Garrett Oakland, MD 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Yaar If Undar 24 Hrs.

Months Days Hours Min. 8. Data of Birth (Month, Day, Year) 02-02-1905 Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. lest birthday) **Funeral** 95 216-07-5267 MD Director Usual Residence of Decedent filed within 72 hours efter deeth with the Meryland Hygiene. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Herns 23s or 28s-f show ther must be notified at 1 XYes 2 No Director Kitzmiller, MD MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21538 P.O. Box 51 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 Ď No If Yes, Giva Yeer or Datas: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "naturel", or 1 ☐ Yes 2 No Specify: White à 3 X Widowed 4 □ Divorced Completed 7 is marked other than "natu treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Coal Miner permit. Peges 1 and 2 should be file Deportment of Heelth and Mental Hy, Important: If Item 27 is marked oths any Injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mothar's Nema (First, Middle, Meiden Sumema) Be John W. Wilson Myrtle Pew 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Box 515 Kitzmiller, MD 21538 Eola Reel 20b. Piace of Disposition (Nema of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burlel 2 □ Cremetion 3 □ Removal from State I.O.O.F. Cemetery 12/18/00 Elk Garden, WV 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Nama and Address of Facility Burdock Funeral Home Kitzmiller, MD 21538 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** congestive Heart Fail ure /Medical Immediate Cause (Final months disaasa or condition resulting In death) Examiner Dua to (or as a consequence of): Physician/Medical Examiner physician end s the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated evants resulting in deeth) Lest Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Dua to (or es a consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Preummia þ Acute Regpiratory Distress Syndrome performed? 24b. Were autopsy findings available prior to completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Placa of Deeth (Check only ona) Hospital: 1□ Yes 2☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA funeral 27. Menner of Death 28e. Deta of Injury (Month, Dey Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending investigation or Attending 1 Naturel 1 Yes 2 No 2 Accident ofter death Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide • Funeral Hospital edicai 29a. Certifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Madical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signeture and title of certifiar 29d. Date signed (Month, Day, Year)

State Registrar

69 Wolf Acres Drakland, MD 21550 PolainTel 31. Data filed (Month, Day, Year) 32. Registrar's Signature

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**DEC 1 9 2000** 

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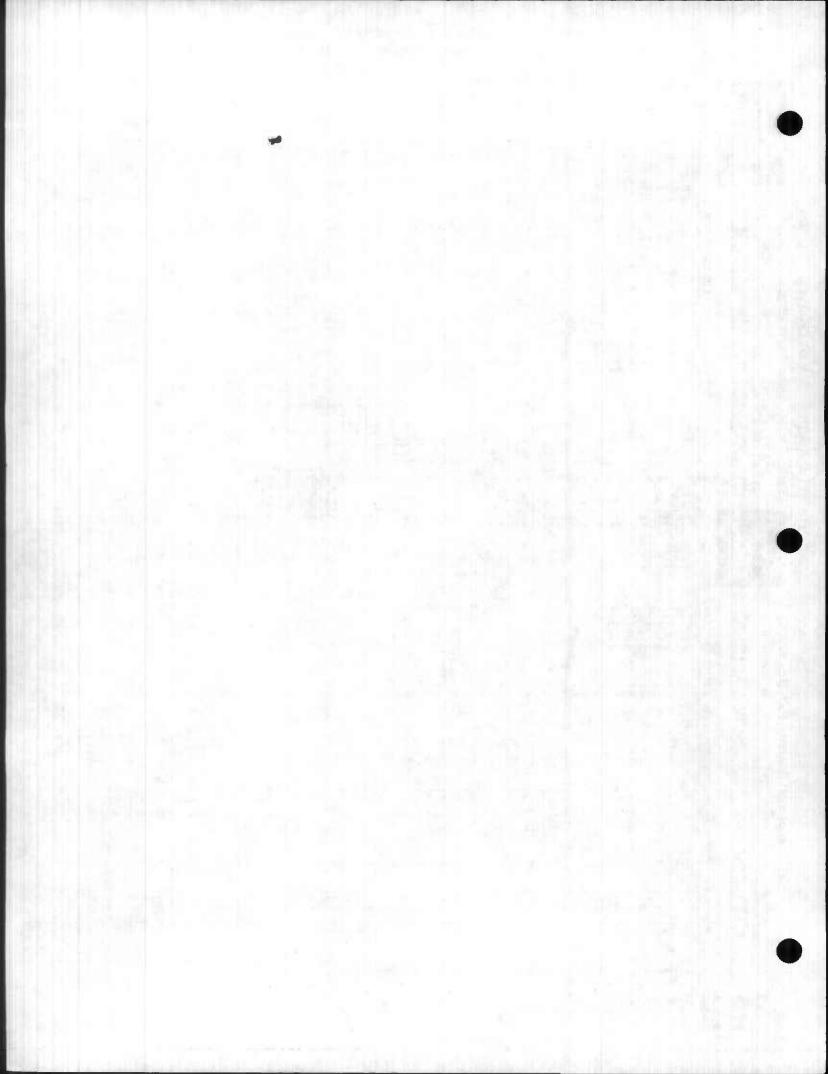
cause of death (Item 23a) (Type, Print)

SECTION OF THE STATE OF THE STA

Petron Jandelle Je Barrel and Thomas

State of Maryland / Department of Health and Mental Hygiene 00 42560

				Certifica	te of D	eath	F	leg. No.		
	1. Decedent's Neme (First, Mic	ddie, Last)					2. Dete of Dee	th Dev	Year	3. Time of Death
sician ledical	AGNES J	. YONKIN					Decembe		000	5:18 PM
	le Facility Name (If not institut	tion, give street and nun	n <i>ber</i> )		4b.	. City, Town, or L				
	Civista Medci	ial Center				LaPlat	a	Cha	rles	
	5. Social Security Number		7. Age (In yrs. las	Month:		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, De)	Year)	9. Birthplee	ce (Stete or Foreig
	170-16-2805	1 M 2 F	81	Yrs.			ugust 2	6, 1919		PA
	Usuel Residence of Decedent 10e. Stete 10b. Cour	ntv	10c City	Town or Location					100	I. Inside City Limits
									100	1 ☐ Yes 2 ☐XNo
Director	PA PO1	tter	(	Galeton	ip Code			10g. Citizen of \	Affroi Countr	
히	25 Germania	Poad		101. 2	1692	2				'
Funeral	11. Meritel Status		dent Ever in U,S.	13 Was Dec			ecity Yes or No-	USA 14. Bac	e - American	Indien.
3	1 Never Married 2 M	Armed For	rces?	If Yes, sp	ecify Cuben,	panic Origin? (Sp , Mexican, Puerto	Rican, etc.)	Blee	ck, White, etc	
	3 ☑ Widowed 4 □ Divorc	If YAS GIV	8	1 ☐ Yes		Specify	v: Whi	te		
	15. Deced	ent's Education		16a. Decedent's Us	ual Occupati	ion		16b. Kind of Business/Industry		
5		hest grede completed)  College (1	Apr 51)	(Give kind of v	vork done du use retired)	iring most of work				
	Elementary/Secondery (0-12	) College (1	-40( 5+)	Lab	or		Manufacturing			
De Completed	17. Father's Neme (First, Midd	le, Last)			1	18. Mother's Nem	e (First, Middle,	Maiden Sumen	n <i>e)</i>	
0	Frank Gallig	gher			1983	Elizabe	th Keis	enwalte	r Gall	igher
	19a. Informent's Name/Relation	nship (Type, Print)		19b. Meiling Addre	ss (Street en	nd Number or Ru	rel Route Numbe	r, City or Town,	Stete, Zip C	ode)
	Richard Youl	cin/Son	1027	239 Germ	ania '	Road, Ga	leton.P	A. 1692	2	
2	20e. Method of Disposition		con	ce of Disposition (N	ame of		Date	20c. Location -		n, State
	1 XBuriel 2 Cremetio 4 Donetion 5 Other		State	mania Cen			2/29/00	Galeto	n.PA.	
2	21. Signety e of Funeral Service	no Liconego	M00945			e Facility ECHOLS F				
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	23e. Pert1. Enter the disease, shock, or heart failure.	or complications that co	aused the deeth.						. A	Approximete Interval Between
Medic	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest	6. CO	Due to (or e	as a consequence of	10C	ARDIA	HCIA Y P	I FRR	STOOL	1 48H
Completed by Physician/							1	.730	1	
P	Pert II. Other eignificant cond	πions contributing to de	ath but not resulti	ing in the underlying	cause giver	n in Pert I.			ontribute to t 3 ☐ Proba	he cause of death
	SEVERI	1 10	KHIC	- 5+	CN	2100		res 2□ No	0 F1008	- TOPIKITO
	RENA	L FA	MLU	RE	gbb		24a. Wes pario	an eutopsy med?	com	e autopsy tindings able prior to pletion of cause seth?
E							10)	es 2 Line		Yes 2□ No
5	25. Was case referred to medi	cal				26. Placa of Dea				
To Be	examiner?	Hospitel: 1	nnatient all E	R/Outpatient 3 1	Other		ome 5 Resid		ner (Snecifi)	
2	27. Menner of Deeth	28a. Date of		8b. Time of	28c. Injury o	-	28d. Describe h			
2	1 Naturel 5 Pen	ding (Mont stigetion	ii, Day rear)	Injury M		es 2 No				
	3 Suicide 6 Cou 4 Homicide dete	28f. Location (S City or Tox	Street end Numi m, Stete)	ber or Rural i	Route Number,					
286. Piece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)  29a. Certifier (Check only 2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and								cause(s) and m date end place,	anner as stal end due to t	ted. he cause(s)
edicai	29a. Certifier 178-Certifi (Check only 2 Medic one) 18-Certifi									
	(Check only 2   Medic	end menr	ner steted.	2	9c. License	number		29d. Date signe	ed (Month, Di	ay, Year)
	(Check only 2   Medic one)	end menr	Ler steled.	2			7	29d. Dale signe	2 S	ay, Year) 200(
Medica	(Check only 2   Medic one)	end menr	1			0044436	7	29d. Dale signe		
2 2	(Check only 2   Medicone)  29b. Signeture and title of carr	end menr	e of deeth (Item 2	23a) (Type, Print)	D -	0044436	ī	DEC		



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certificate of Death					Reg. No.				
	_	1. Decedent's Nama (First, Middle, La	st)	94	186			1-10-		2. Data of Death		V	3. Tima of Death
Physicia	_	Bernice	Mordica			Zos	3			December	7, 200	00"	7:00 AM
/Medica Examine	-	4a Facility Name (If not institution, given St. Mary's Nurs:							own, or Lo	ocation of Death	4c. County		s
Funeral Director		5. Social Security Number  230-18-0227  Usual Residence of Decedent	6ex 7. Age 7. Age 7. Age 7. Age 7.	(In yrs. las	st birthday) Yrs.	If Undar Months	1 Year Days		24 Hrs. Min.	8. Date of Birth (Month, Day, ) April 13			lace (State or Fore try) rginia
**************************************	ctor	10a. State 10b. County Virginia Princess 10e. Street and Number	Anne		Town or Lo					103	g. Citizen of W		0d. Inside City Limi 1 ☐ Yes 2 ☑ N try?
23a	9	3558 Shore Drive				23	455	-1707			US	USA	
5 2 E	by Fur	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:			Was Deced If Yes, spe- 1  Yes				ecify Yes or No- Rican, etc.)	Blac	a - America k, Whita, d Whi	atc.
natur Ical	ted	15. Decedent's Ed	ducation		16a. Deced	dent's Usua	s Usual Occupation 16b. Kind of Business/Industry of work done during most of working VOT use retired)					Justry	
Mai y latta L. L. 13-00-00 d 2 should be filed within 72 hours of th and Mattel Hygiers of 17 is marked other than "natural", or trsummite event, the Medical Euron	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5 2 years	+)		ster			of Work	Medical			
e filed al Hygid other vent,	36	17. Father's Name (First, Middle, Last,	)				18. Mother's Nama (First, Middle, Maiden Surname)						
should be nd Mental marked urratic ev	0	Bernard Al	.len	Mor	Mordica Clara						Richan	cdson	
2 sho end I		19a. Informant's Neme/Relationship (	**	454	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip								
1 and 1 Heelth tsm 27 other tr	-	Alexis Zoss (Daug 20a. Method of Disposition	hter)	sition (Na	ne of		nard	town, Mar					
permit. Peges 1 and 2 should be filed within Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the back.		1 Burial 2 To Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Brinsfield-Echols 12/9/2000 Charlotte Hal											1, Maryl
permit. Departimental any injudical		21. Superform of unergoing the common state of								oad, Leonardtown, Maryland			
- OI W	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury that initiated evants resulting in death) Last	b	Due to (or a	as a consec as a consec as a consec	quence of):							
deeth cert e attendin id for use	an		d										
et the de di by the etached	P N	Part II. Other significant conditions of	contributing to death bu	ut not result	ing In the u	nderlying o	ause g	iven in Part	I.		acco use cor	3 🗍 Prol	bably 4 Unknown
aw requir as been s 2 should	Completed by	Polymyalgi Annlin De	a Rheum	Au	bete	Me	lle	tas		24a. Was an perform	ed?	evi co of	ere autopsy finding allable prior to mpletion of cause death?
hysician: his certifical al director	10 Be	25. Was case referred to medical examiner? 1	Hospital: 1 ☐ Inpatie  28a. Date of Injur (Month, Day		R/Outpatier 28b. Time o Injury		28c. Inji	ther: 41 N	ursing Ho	th (Check only one ome 5 Thesider 28d. Describe how	ice 6 🗆 Oth		y)
or At after of Direct I in by	27. Manager of Death 1 Naturel 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M York?  28c. Injury at Work? 1 Yes 28c. Place of Injury M 28c. Injury at Mork? 1 Yes						•		28f. Location (Str. City or Town,		er or Rura	al Route Number,	
To the Hospital or At within 24 hours after To the Funeral Direct completely filled in by	Medical		nysician: To the best of the basis of the ba	axaminatio									
To the young	Ž	29b. Signatura and titla of certifing	1/	-		29	c. Licar	nsa number		29	d. Data signe	d (Month,	Day, Year)
)		1/1	4	7			11	991	7		14/8/	100	
de			completed games of de	eeth (Item 2	23a) (Type,		alif	fornia	, Ma	ryland 20	0619		
State		31. Data filed (Month, Day, Year)	32. Registra	ar's Signatu	ire /		6-						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AM She 2 mes ldon 20,2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location unty of Deat Examiner 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 100M 20 F Months Days Hours Min 217-50-217-50-2367 Usuat Residence of Decedent 54 Yrs. Director Feb 171 permit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". It is marked other than "natural". It is marked other than "natural". It is marked other than "natural". 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 212 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever In U.S. Armed Forces? 1 DYes 2 □ No IYes, Give Year or Dates: V 1 € +NQM Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retiped). 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) STRUCS 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Evans Funeral Chapel-Bellie 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses vans Car. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, su(h) as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate thervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) COMA Examiner Physician/Medical Examiner Arlen The lew requires that the death certificete be executed physician end s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Records, P.O. Box 68760, Due to (or as a consequence of): 98 for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the a signed by t 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? should I 24a. Was an autopsy Completed pege 2 s certificete 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospitat: 0 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours effer death.

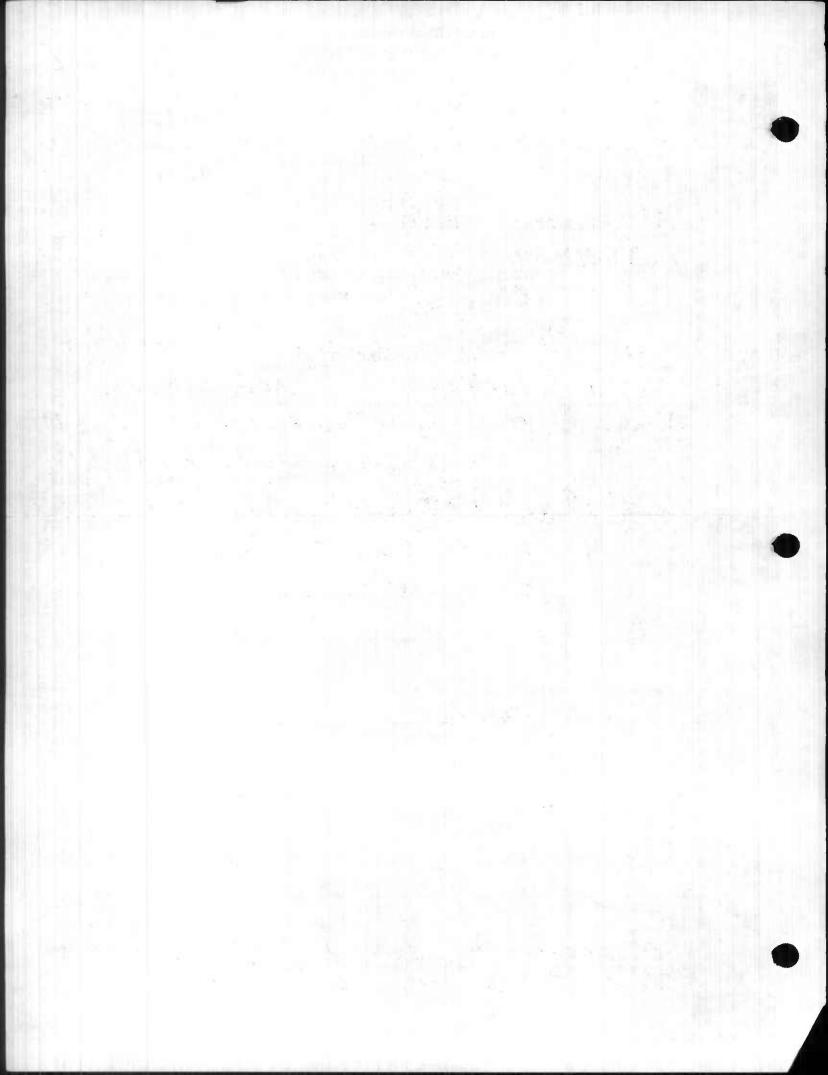
Funeral Director: After this detery filled in by the funeral director. 28d. Describe how Injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospitai 1 Phyeician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end manner es steted.

2 Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical pletely (Check only one) within 2 29b. Signature and title of cartifier 29c. License number 252 Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NNell. Baltimore ma 0 31. Date filed (Month, Day, Year) JAN 0 5

32. Registrar's Signature

rocks

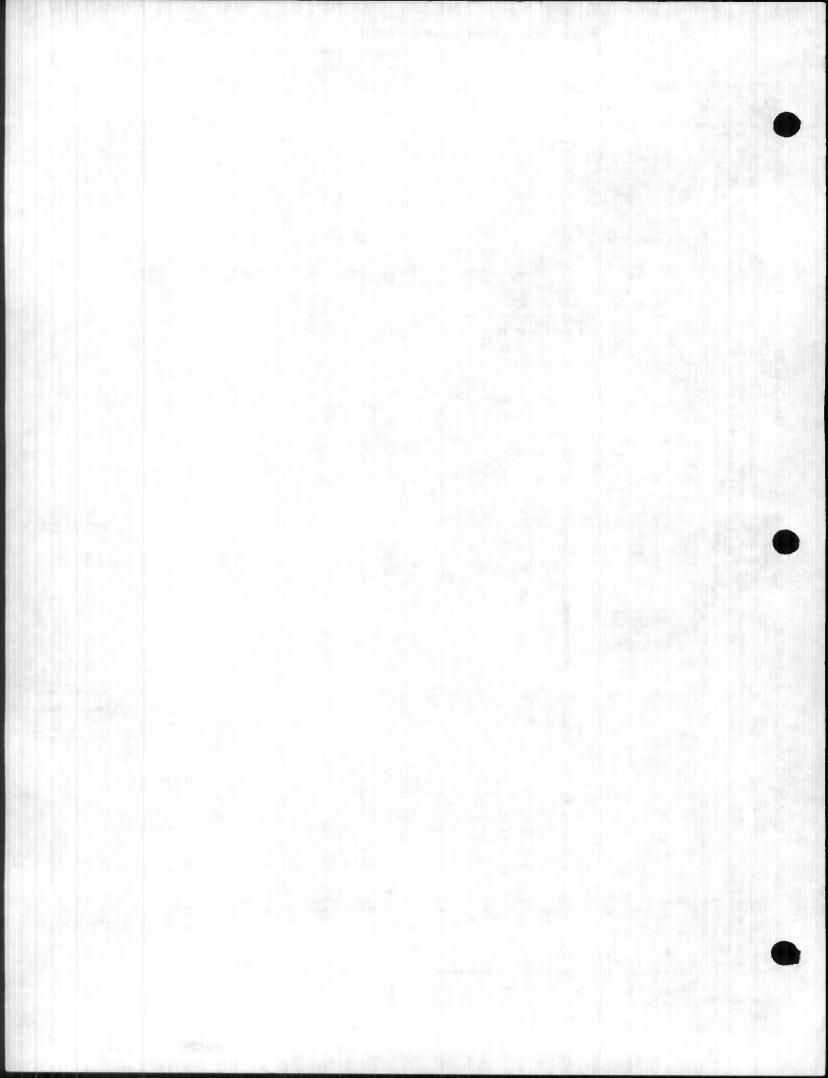
State Registra



State of Maryland / Department of Health and Mental Hygiene 0 4 2 5 6 3

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0 2 0		reet and Num		. 6			10	7. Zip Code 21787			10g. Citizen of What Country? U.S.A.				
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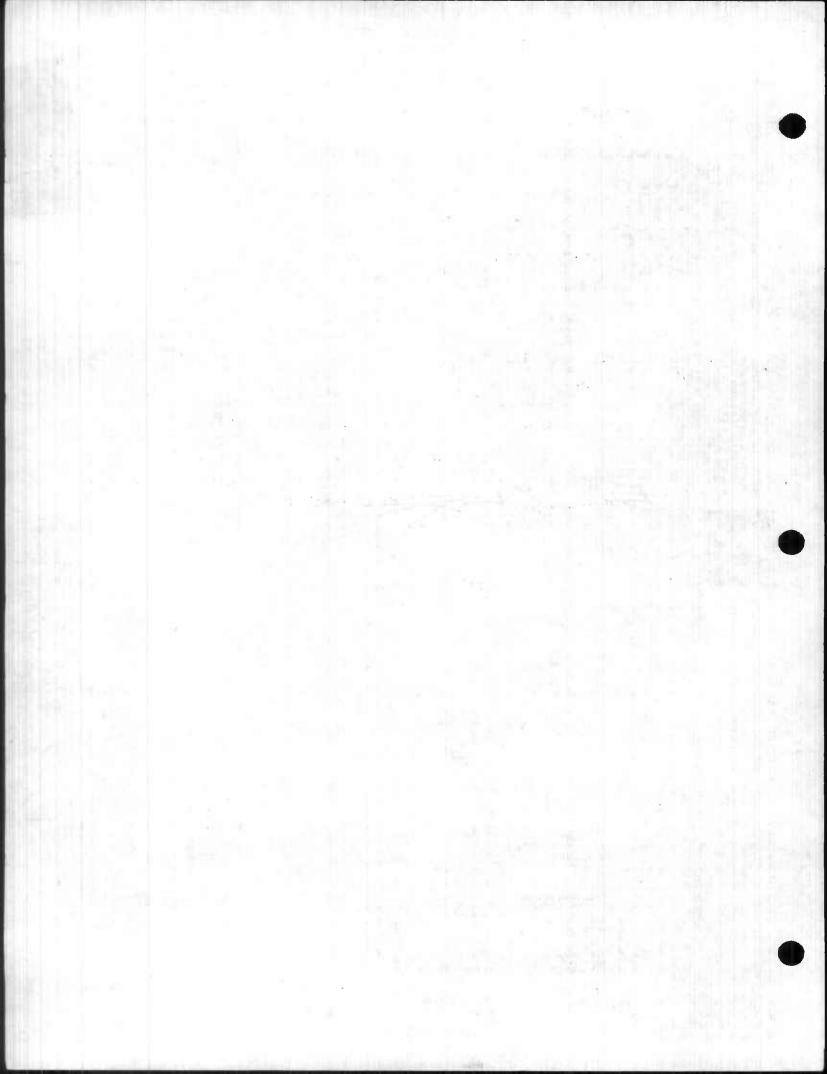
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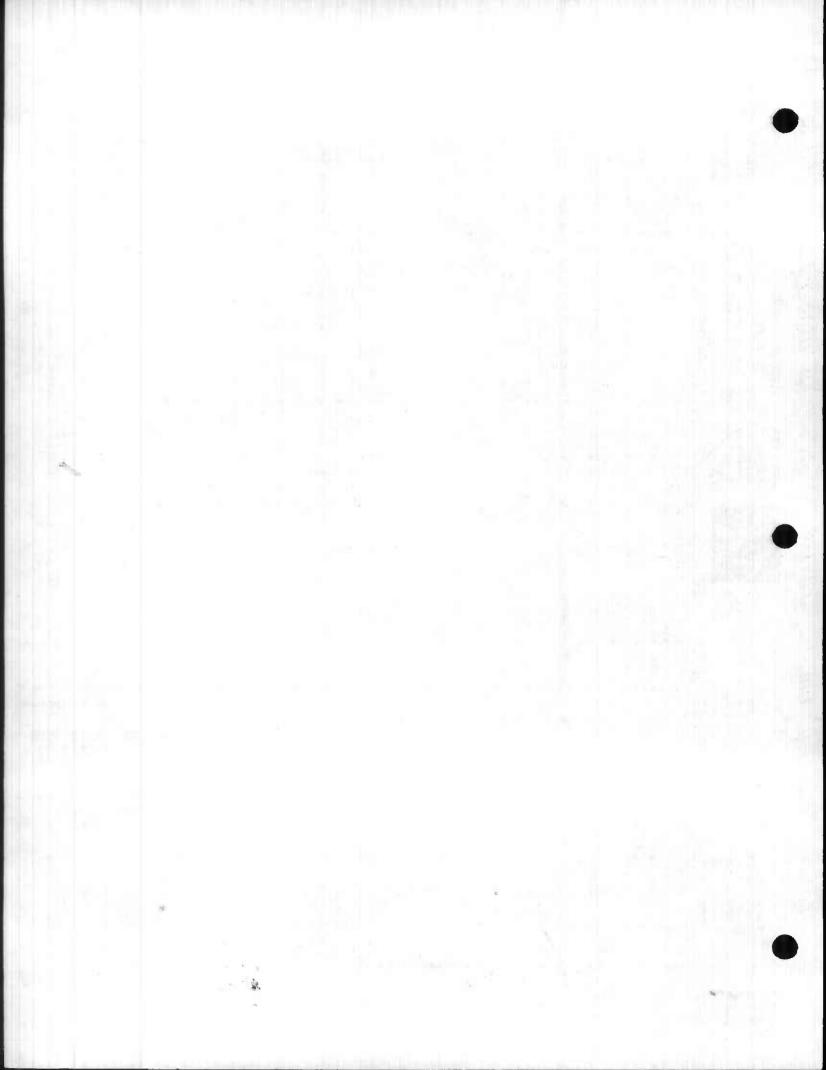
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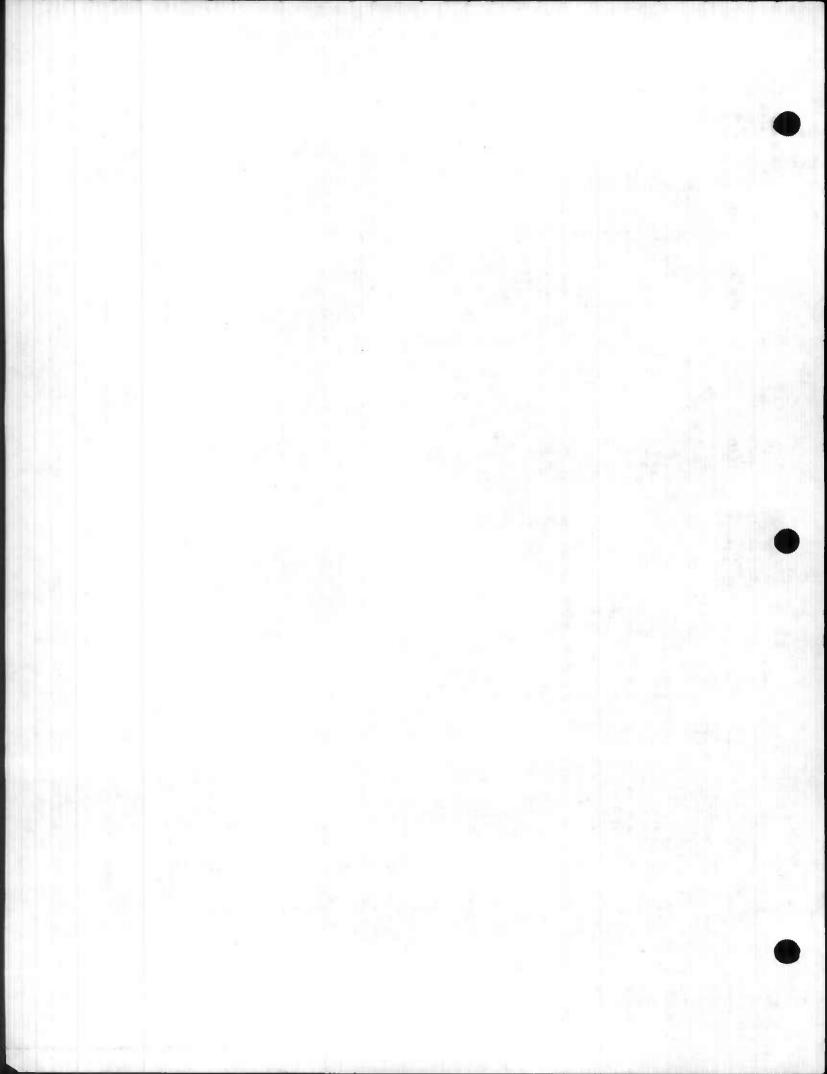
Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene County Certificate of Death AMENDED ITEM #7 per fh G791 010501 SS 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 4:00pm Margaret P Blondell 29 2000 Dec. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care - Rossville Rossville **Baltimore** H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DeC • 29 1914 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2□F 216-05-1785 87 Yrs 86 Director **MAryland** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Baltimore** MD **Baltimore** X□ Yes 2□ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 349 Folcroft Street 21224 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 20 No 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White ¥₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerica1 12th Cross & Blackwell 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Adam Paul Erna Gessing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon Forster 7851 Wynbrook Road Baltimore Md. 21224 altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/3/2001 Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Balitmore MD 22. Name and Address of Facility 21. Signature of Funeral Service License Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** acute My ocardra Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine physicien end s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medicai Due to (or as a consequence of): -BAL 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 thinknown signed I à 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vitai Be 25. Was case reterred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 PNatural THROAKET 5 Pending investigation 1 Yes 2 No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 ☐ Homicide 24 hours Describing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 vithe F complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 037612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dive, 20 Bel AIR MO21014 ALABRASH, MD 1201 000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar IAN 0 5 2001 **DHMH 16 Rev 6/95** 

ORIGINAL



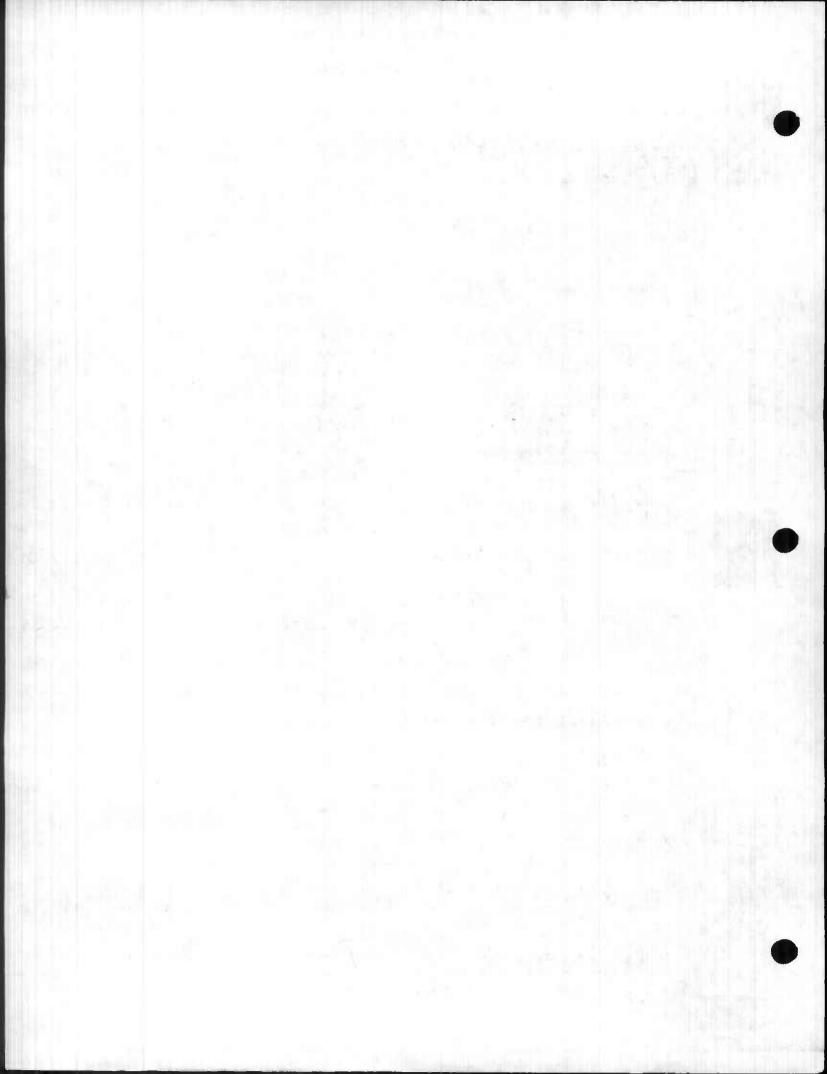
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Physician	Decedent'a Nama (First, Middla, Last)     M.	ARIE T BU	RGER		2. Deta of Deeth Month	Day Y	3. Time of Deeth
/Medical Examiner	4a Facility Name (If not institution, giva street and no	umber)		4b. City, Town, or Lo	A	4c. County of	
LAdminici	Upper Chesapeake He	ospita1		Belair		Harf	ord
Funeral Director	5. Social Security Number 212–16–0523 6. Sex	7. Age (In yrs. lest birthd	Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, ) Dec • 24	1910	o. Birthplaca (Steta or Foreign Country) Maryland
Maryland f show led at	Usual Residance of Decedent  10a. Stete 10b. County  MD Baltimore	10c. City, Town o	r Location	Baltim	ore		10d. Inside City Limits  **TYPE 2 \[ \] No
) A with the Ma 3a or 28a-f a at De notified	10e. Street and Number 508 North Clinton St	reet	10f. Zip Code	21205	109	g. Citizen of Who USA	
7 / L 0. 1020 ours after death wif, or fame 23 Examiner must	Armed F	2000No Sive	13. Wes Decedent of If Yes, specify Cut	Hispanic Origin? (Spe pan, Mexican, Puerto I Specify:	city Yes or No- Rican, atc.)		Americen Indien, White, etc. White
Maryland 21215-0020 Maryland 21215-0020 at 2 should be filed within 72 hours all the and Marinal Hygiere. The marked other than "natural", or traumed other than "natural", or traumed other than "natural", or traumed other than "natural", or To Be Completed by F	15. Decedent's Education (Specify only highest greda completed) Elementary/Secondary (0-12) College	(1-4or 5+)	ecedent's Usual Occu give kind of work done fe. DO NOT use retire Homemaker	pation a during most of working ad)	ng 10	6b. Kind of Busin	ness/Industry  home
Viand 2 Viand 2 Viential Hyginal Hyginal Other Interest other To Be Co	17. Fathar's Nama (First, Middla, Last) Roman Wyczaleck			18. Mother's Name MAry	(First, Middle, Mid Kwarcin		
	19e. Informant's Name/Relationship (Type, Print) Thomas Burger / son	r end Number or Rura Road Bal	timore M	D 2122	1		
Buttimore, Ma Baltimore, Ma Baparimori of Hauth a Maporiant, if Hauth a my Injury or other trau	20e. Method of Disposition  1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from 4 ☐ Donetion 5 ☐ Other (Specify)	Date 26	Balitm	ore Maryland			
Ball Ball Ball Ball Ball Ball Ball Ball	21. Signature of Funaral Servica Licensee	mully	- 300 MAC	y Funeral e Ave. Bal	timore M	D 21221	
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that ahock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in deeth)	st,	Approximate intervel Between Onset and Death  2 3 - 4 week				
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Vital I	25. Was case referred to medicet exeminer?		10	26. Place of Deeth	(Check only one	)	
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Division of Vital Records, or Attending Physician: The lew requires the effect death.  Birector: Affect this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	2 Accident invastigation 3 Suicide 6 Could not be	e of Injury  nth, Dey Year)  28b. Tim  Inju  ce of Injury - At home, farm	M 1[	Yes 2 No			r or Rural Route Number,
Division of To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: Affer the completely filled in by the funeral Medical Certification:	4 Homicide determined 20e. Flact bulk	ding, etc. (Specify)		30-1	City or Town,	State)	
Di To the Hospital or within 24 hours effe To the Funeral Dir completely filled in Medical Ceri	(Check only 2 Medical Examiner: On the	besis of examination end/onner stated.	or investigation, in my	opinion, deeth occurr	ed et the time, da	te end place, ar	(Month, Day, Year)
	30. Name and address of person who completed cau	Worker Touse of death (Item 23a) (Ty	1 D FACT	D50	1040	01.0	01.01
State	Business Center Way	H 102 Registrar's Signature	Edger	oed, M	D 21	040	
Registrar	JAN 0 0 2001	100 PS	apark	3			

DHMH 16 Rev 6/95



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	State of Maryland / Department of Health and Mental Hygiene	4	2	5	6
	Cartificate of Dooth				

			Certificate of Death		g. No.	72001	
	Decedent'a Name (First, Middle, Last)			2. Date of Deat	1	3. Time of Death	
Physician	Elizabeth	Edith	CAIN	Decembe	V 30 200	1	
/Medical Examiner	4a Facility Name (If not institution, give street	ot and number)	4b. City, Tor	wn, or Location of Death	4c. County of D		
LAdillilei	The Good Somaritan	Hospital of	maniford Ba	1timore			
Funeval	5. Social Security Number 6. Sex	7. Age (In yrs. last/birthe	day) If Under 1 Year   If Under:	24 Hrs. 8. Date of Birth	9.1	Birthplace (State or Foreig	
Funeral Director	717-07-11-02 10M		Months   Davs   Hours	Min. (Month, Day,	1011 1	Country 1/24	
	Usual Residence of Decedent	0 1		Ving as	1 111	ucequaries	
dand dand	10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limit	
within 72 hours after death with the Maryland within 72 hours after death with the Maryland than "heaturel", or fems 23s or 28s-f show he Hedical Examiner must be notified at Maryland Examiner must be notified at Maryland	Md Happed land					1 ☐ Yes 2 No	
	10e. Street and Number 10f. Zip Code 10g. Citizan of What Country?						
	1110 Harding				1101		
	11 Marital Status 12.V	Was Decedent Ever in U,S.	13 Was Decedent of Hispanic Ori	nin? (Specify Vas or No-	14 Bace - A	merican Indian,	
er de la la la la la la la la la la la la la	Armed Forces? It Yes, specify Cuban, Mexican, Puerto			, Puerto Rican, etc.)	Rican, etc.) Black, White, etc.		
urs aft	1 Never Married 2 Married 3 Wildowed 4 Divorced	I ☐ Yes 2 D No If Yes, Give Year or Dates:	1 ☐ Yes 2 Ho Specify:		Specity:	)hite	
"natural", or adical Exam leted by F					16b. Kind of Busine	ac/ladueta:	
ed within 72 ho ygiene. r. tre then "neture ft, tre thencel	15. Decedent's Education (Specify only highest grade con	npleted)	ecedent's Osual Occupation Give kind of work done during most ife. DO NOT usa ratired)	of working	0 1 1.	SS/IIIOUSITY	
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2 4 4				or or Rural Route Number,			
Haalth Item 27 other tr	Judish C. Cantalupo 410 Hardin Dr. Jooga Maryland					21085	
of He	20a. Method of Disposition	comotos:	Disposition (Name of crematory or other place)		20c. Location - City	or Town, State	
	12 Burial 2 Cremation 3 Removal from State (Specify)  A Donation 5 Other (Specify)  A Donation 5 Other (Specify)						
permit. Departr Importa any Inje							
	25a. Párti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate						
P4.	shock, or heart tailure. List only one ca	ause on each line.	t entar tha moda ot dying, such as	cardiac or respiratory arre	JST,	Approximata tritarval Between Onset and Death	
Physician	Immediate Cause (Final disease or condition Preumonia 3 weeks						
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	Due to (or as a consequence ot):						
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death e ath ed fo	Part II. Other significant conditions contribu	uting to death but not resulting in f	he underlying cause given in Part I	. 23b. Did to	bacco use contrib	ute to the cause of deat	
The law requires that the death cert page 2 should be detached for use.  Completed by Physician/M					1 Yes 2 No 3 Probably 4 Unknow		
than hed a de de de de de	Cerebro Vascular accident				7		
or Attanding Physician: The law requires that the death certificate after death.  Silvector: After this cartificate has been signed by the attending physic in by the funeral director, page 2 should be detached for use as the artification: To Be Completed by Physician/Medici	Esophagitis			24a. Was a	24a. Was an autopsy performed? 24b. Were autopsy available prior completion of of death?		
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has has ye 2		12			~		
cate h	Peripheral Vasaular disease				s 2 No	1 ☐ Yes 2 ☐ No	
Physician: The lave this cardificate has ral director, page 2.	25. Was case reterred to medicat axaminer?						
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har thar there							
ati	2 Accident investigation M 1 Yes 2 No						
ar de la la la la la la la la la la la la la	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, streat, factory, offica building, atc. (Specify)			28t. Location (St City or Town	8t. Location (Street and Number or Rural Route Number, City or Town, State)		
us or Attending P rs after death. si Director: After t led in by the funer Certification:							
hour hour liners by fills	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.						
To the Hospital or Attanding Ph within 24 hours after death. To the Fureral Director: After th gompletaly filled in by the funeral Medical Certification: 7	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.						
Nithir Nomp	29b. Signature and title of captitier 29c. Licanse number				29d. Date signed (Month, Day, Year)		
0	Did Go MD DIMINI			7	December 30 200		
W.	20 Name and officer of correct who correct	ated course of death (them one)	una Print)	1 600	ecembe	130,000	
188	QuyIn Gao, MD P14417  December 30, 2000  30. Name and 300 person who completed cause of death (Item 23a) (Type, Print)  Stol Loch Raven  Boulevard, Baltimore, MD 21239-3995  31. Date tiled (Month, Day, Year)  32. Registrar's Signature						
	31. Date tiled (Month, Day, Year)	32. Registrar's Signature	, paltimore,	MD 21259	-0993		
State	IAN 0 5 2001	Jz. Hogistrai s Signature	6 /				
Registrar	WHILE OF COOL	1 - 120	1 BOOM NO				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 4 2 5 6 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Year Month **Physician** 12:10 AM December PAULA 26 2000 COOK /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Sinai Hospital of Baltimure Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (in yrs. lest birthdey) Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 10M 2F **Funeral** Months Days Hours Yrs. Director 217-54-1037 MARYLAND FEB.6.1951 Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23e or 28e-f show iner mast be notified at 1 Yes 2 No Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code SOUTHWAY 21215

13. Was Decedent of Hispanic Origin? (Specify Yas or NoIf Yas, specify Cuban, Mexican, Puarto Rican, etc.) Funeral LOYOLA 2651 14. Race - American Indian, 12. Was Decedant Evar in U,S.
Armed Forces?
1 Yes 2 No
If Yas, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes 2 No "natural", or Specify by 3 ☐ Widowed 4 Divorced BLACK Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) flled within Hygiens. College (1-4or 5+) Elementery/Secondery (0-12) 12th MEDICAL RECEPTIONIST NURSING 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 88 and Mental b JAMES BAKER ESTELLE CARTER and / 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. informent's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health as Important! If Item 27 is any injury or other trau. 2008. CHANTREL BRIDGEFORTH-DAUGHTER 2651 LOYOLA SOUTHWAY BALTO MD 20c. Location - City or Town, State 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 4 ☐ Donation 5 ☐ Othar (Specify) VOSHELL MEM. GARDENS 12/29/00 DUNDALK MD. 21. Signature of Funeral Service License 22. Name and Addrass of Facility LEWIS T. GWYNN LEWIS T.GWYNN FUNERAL HOME Teven 4517 PARK HEIGHTS AVE. BALTO.MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Depsis Examiner Due to (or es a consequence of): Examine ed by the attending physician and detached for use as the burial-transit law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by should be detacl 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to complation of ceuse of death? 24a. Was an autopsy Completed performed' page 2 The 1 Yes 2 No 2 No 1 Yes this certificate Division of Vital Physician: 25. Was cese referred to medicet Be 26. Piece of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred is after death.
I Director: After to in by the funera 5 Pending investigation tnjury 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Straet and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.

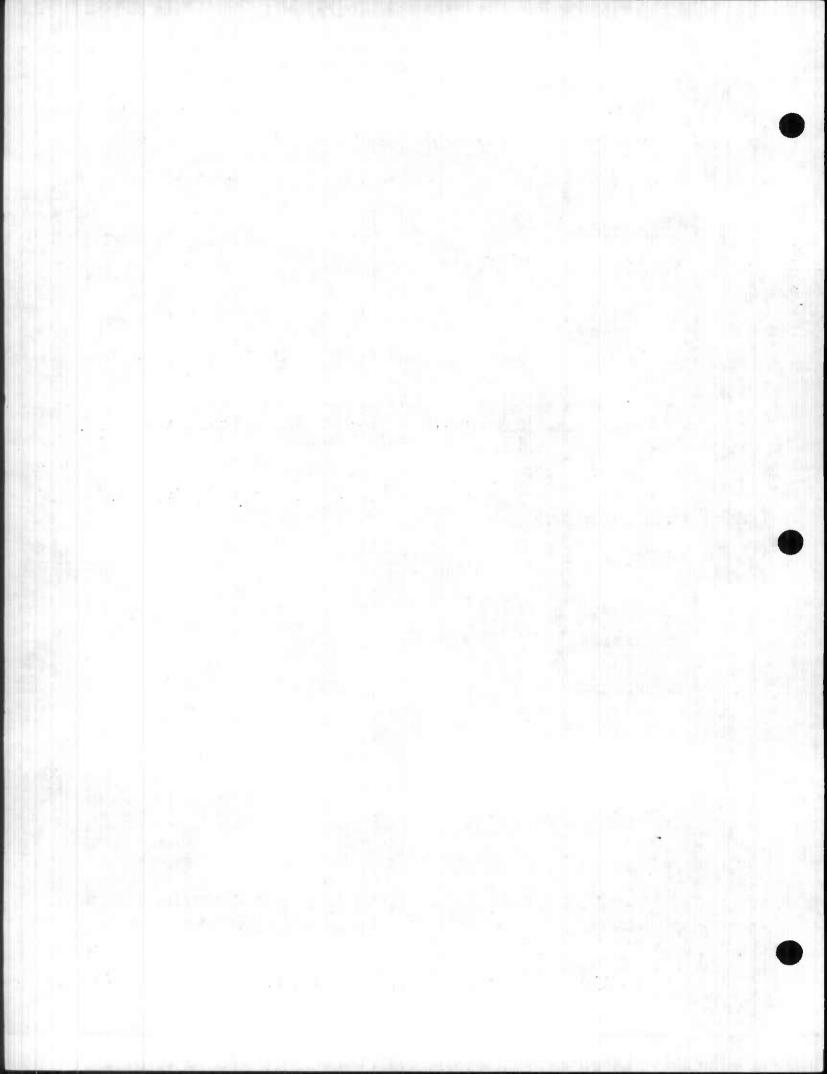
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Data signed (Month. Day, Year) 29c. Licanse number 29b. Signature and title of certifia RES 000 December 26,2000 Celly 30. Nama and addrass of person who completed ceuse of death (Item 23a) (Type, Print) M.D. Sinai Hospital 2401 West Belvedere Ave. Baltimore Evan Jalobson

Registrar

31. Data filed (Months Day, Year)

rocks

32. Registrar's Signature



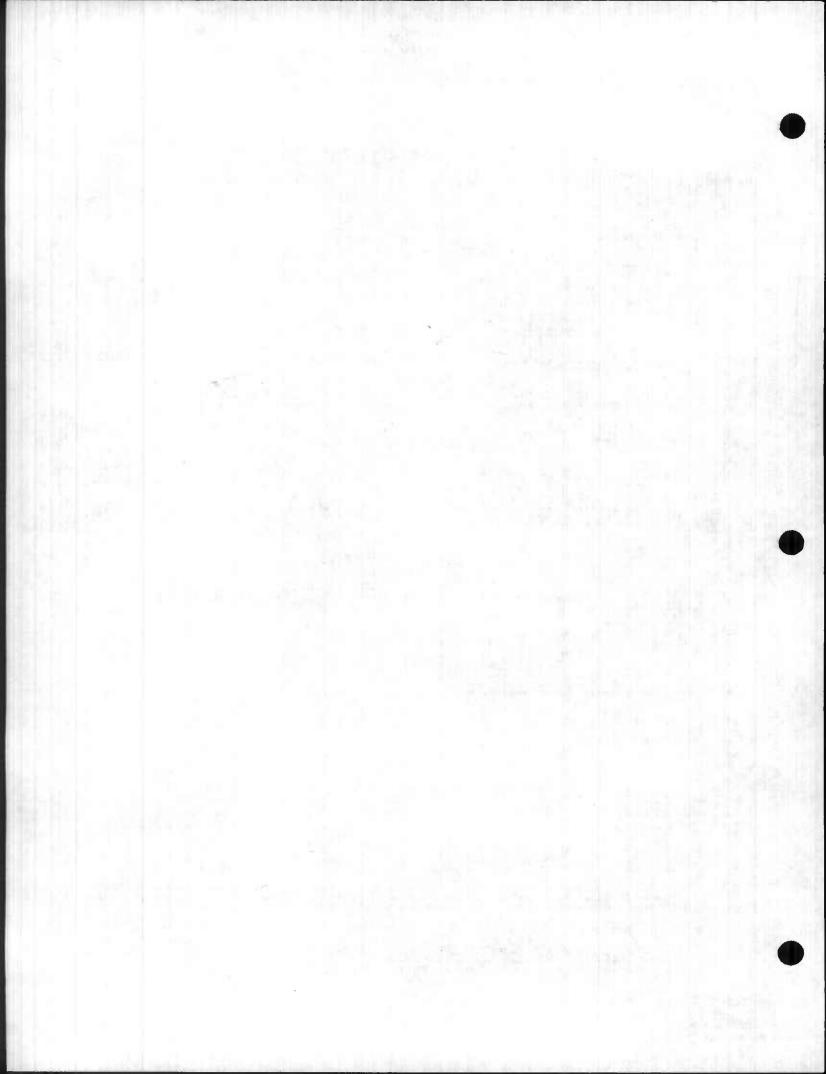
State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** OSOAL /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c, County of Death Examiner Walther Blvd #2202 If Under 24 Hrs 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) li Under 1 Year 6. Sex **Funeral** Months Days Hours 18 M 2□ F -16-94105 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland. In and Mentel Hyglene. The marked other than "natural", or items 23a or 28a-f ahow traumatic event, ma Medical Empires man the notified at 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 881C 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Ves 2 No HYes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specity: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Secu Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Peges 1 and 2 should be nent of Heelth and Mentel Alphonisus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 and 2 and 2 and 2 and 2 and important: If item 27 is any injury or other trauponce. 626 0 Jan 3 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dularcy Valley Men. 2001 22. Name and Address of Facility vans Funeral Chapel 21. Signature of Puneral Service Licentil 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 21234 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical real **Examiner** Physician/Medical Examiner signed by the attending physician and dispersed for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, feeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vitai Records, P.O. Box 68760, Due to (or as a consequence of): Part If. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 ☑ Unknown 1 Yes 2 No by 24b. Were autopsy findings available prior to completion of ceuse of death? been sig 24a. Was an autopsy performed? Completed is certificate has b I director, page 2 sl 2 NO 1 ☐ Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 10 1 Yes 2 No 5 Residence 6 □Other (Specify) this 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred Certification: Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Jan, 2, 2001 N 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Gilleiner 8800 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar 5

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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Amended Item#30 perDVRG791 1/5/2001 EW Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month **Physician** ROGER STANLEY CARLSEN DECEMBER 29, 2000 1:35 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Gaithersburg Montgomery If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (Steta or Foreign Country) **Funeral** Months 1 X M 2 □ F 470-72-2380 81 Director Minnesota Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Gaithersburg 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with r than "natural", or items 23s or the Medical Examiner must be 415 Russell Ave #D611 20877 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ऒ Yes 2 □ No If Yes, Give Year or Detes: ₩WII 14. Race - American Indian, Black, White, atc. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritet Status filed within 72 hours after 1 ☐ Never Merried 2 ☐ Merried 21215-0020 1 ☐ Yes 2 No Specify: white Š 3 Widowed 4 □ Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry I Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) dry cleaner self employed Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Pages 1 and 2 should be 1 nent of Health and Mental I int: If Itsm 27 is marked of Oswald M. Carlsen Hannah Shelbustauk 19e. tntormant's Name/Raletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7329 Carved Stone Rd Nancy Carlsen/daughter Columbia, MD or other t 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Steta 4 Donetion 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee Rohald S. Wade, Pirector Name end Address of Facility
State Anatomy Board 655 W. Baltimore Street wellen 21201 1200 Baltimore, MD 23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximata Intarvet Between Onset end Deeth **Physician** tmmediete Cause (Finet disease or condition resulting in death) /Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Box 68760. Physician/Medical Due to (or es e consequence of) USB P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. 2 24b. Ware autopsy tindings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Be Completed certificate has moner obstre 1 ☐ Yes 2 ☐ No ulmontry deserve Yes or Attending Physician: 25. Was case reterred to medical axaminar? 26. Place of Death (Check only ona) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) Certification: To After this funaral 28a. Data of Injury (Month, Day Year) 27. Manne of Death 28d. Dascribe how injury occurred 28b. Time of 28c. tnjury at Work? 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A! 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical complately (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J. Kabertte

State Registrar

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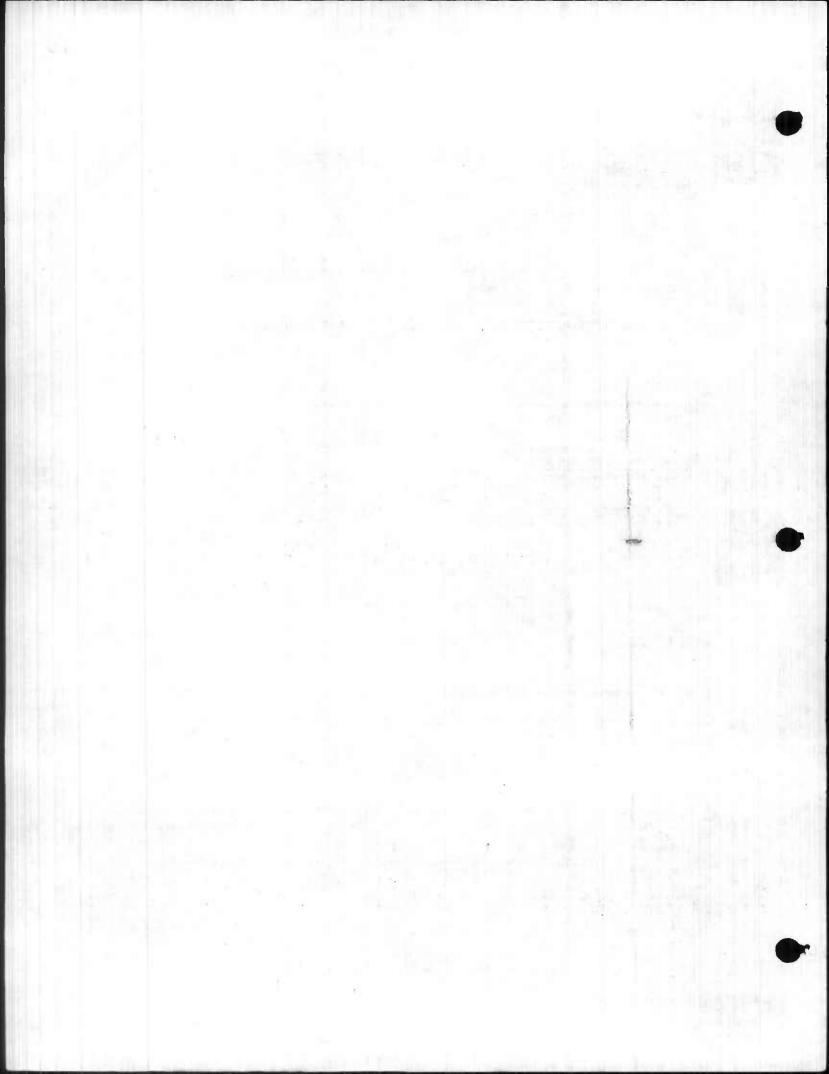
Wilson Health Care Gaithersburg, Md

32. Registrar's Signeture

30. Name and address of person who completed cause of death (ttern 23a) (Type, Print)

H Robert Birschbach

31. Date filed (Month, Day, Year)



State 31. Date Registrar

31. Data filed (Month Day, Year)

JACK M.

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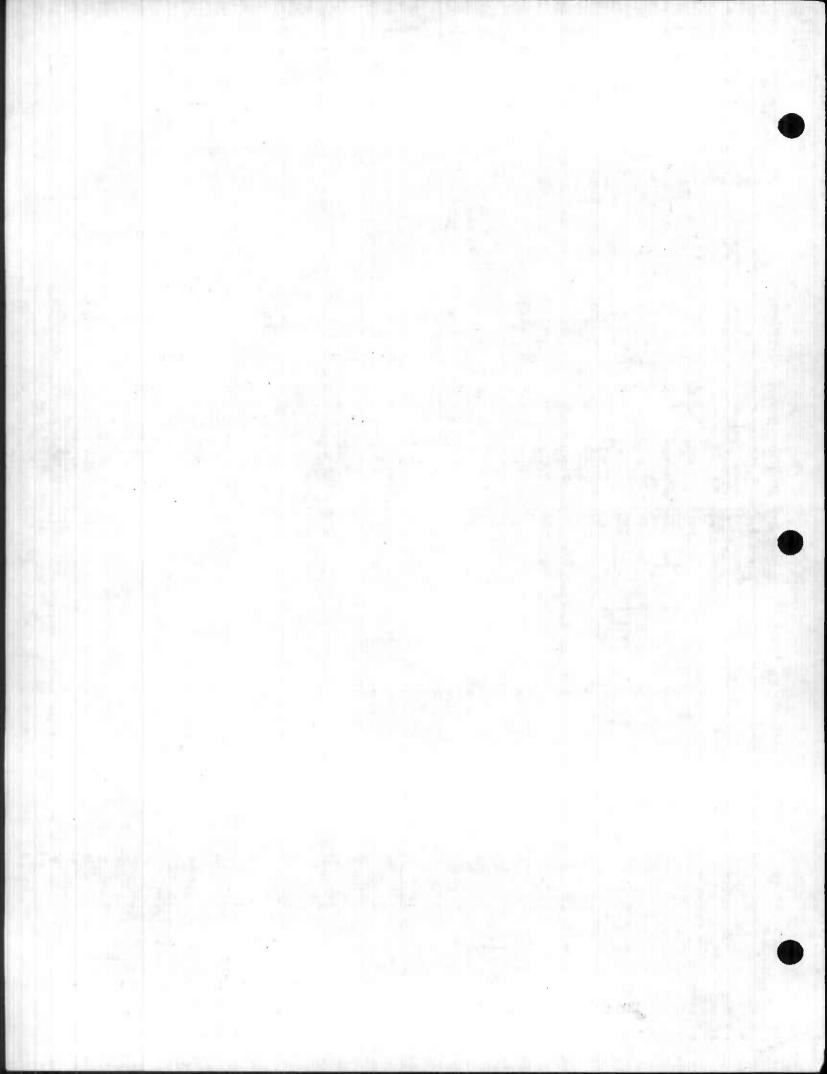
32 Registrat's Signature

who complated causa of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

December 31, 2000



State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year)

JAN 0 5 2001

32. Registrant

30. Name and address of person, why completed ceuse of death (Item 23a) (Type, Print)

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32. Registrar's Signeture

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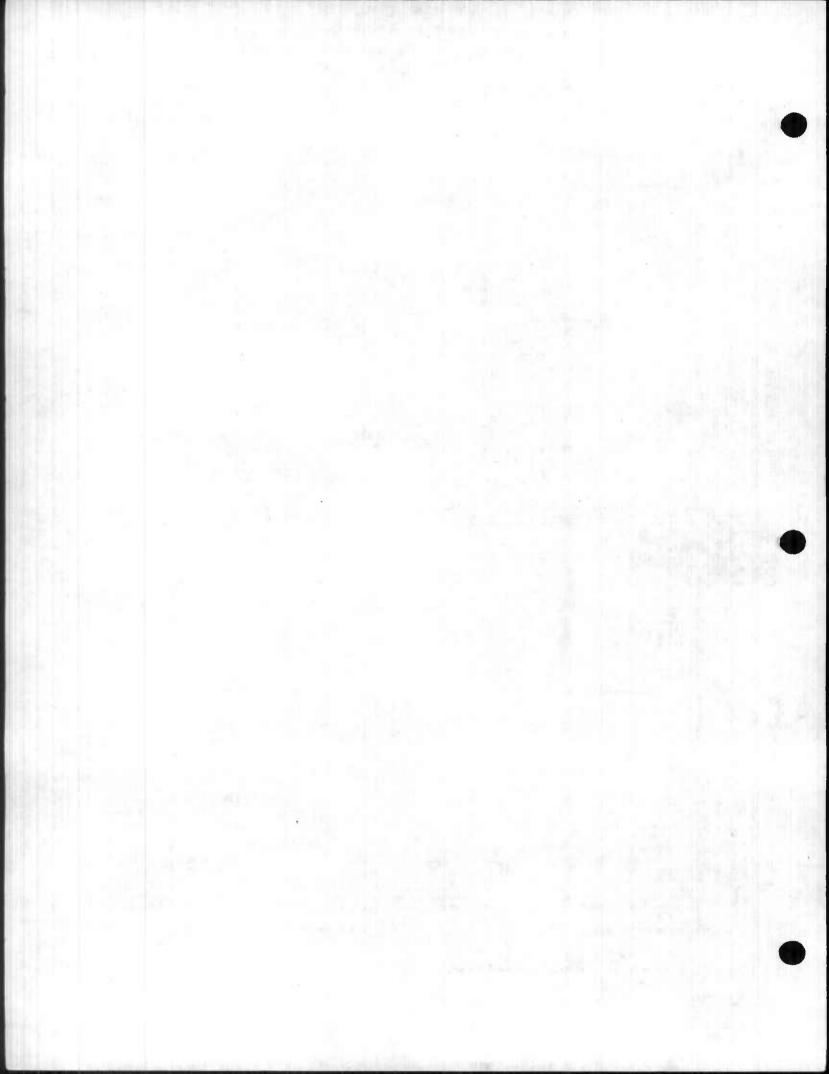
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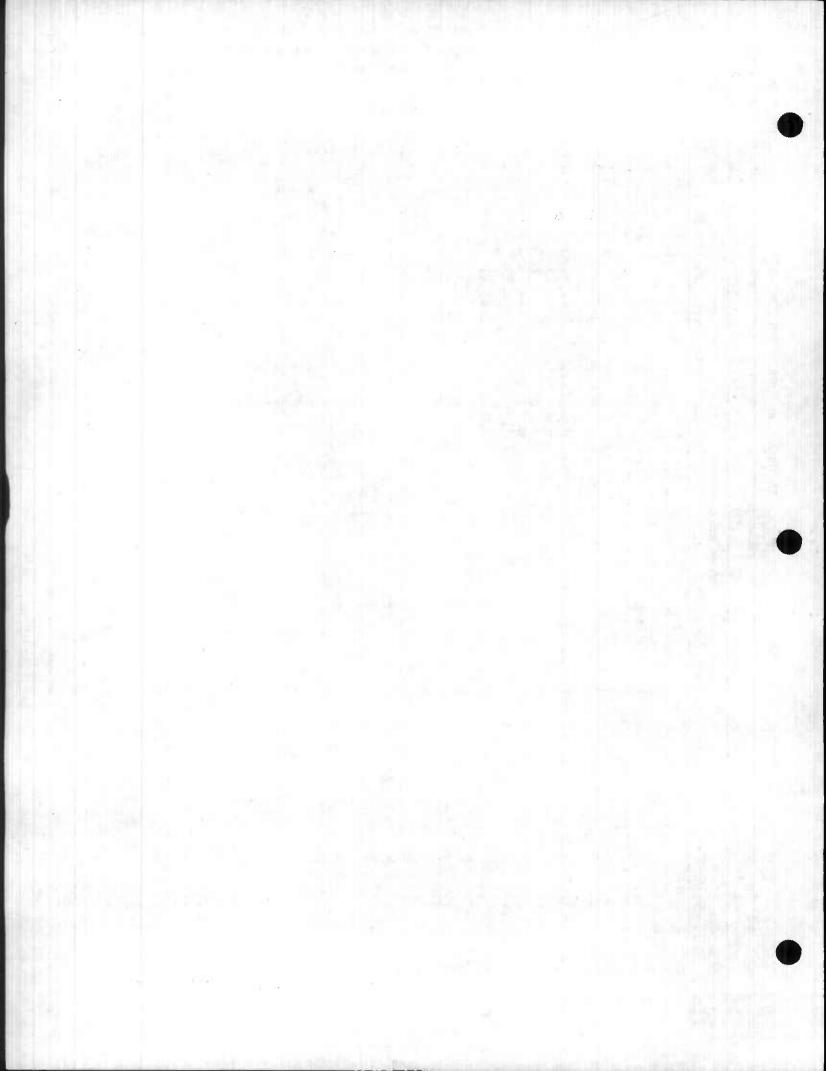
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	Physician	_	LYNN MARIE DEVER								Month Day Year DECEMBER 12,2000 7:35P.						
	/Medica Examine	4.	a Facility Name (If n	not institution, gi	ve street and n	umber)			4	tb. City, To	wn, or Lo	cation of Death	4c. Count				
		_	315 THAYER	RAVE					5	SILVE	R SP	RING	MONTG	OMER:	Y		
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	and	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location											10d. Inside City Limits				
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	n the	1	10e. Street and Number 10f. Zip Code									10g. Citizen of	What Cou	intry?			
	h with	2	815 Thayer Avenue #520 20906								II	SA					
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and	Hate de Hate d	0	7. Father's Name (F Howard O:									First, Middle,					
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Baltimore,	pemit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to ance.	2	21. Signature of Funeral Service Licensee Ronald S. Wede, Director Ronald S. Wede, Director Baltimore, MD 21201											Street			
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			Ken	nis/	hute	W			0	.C.M.	E.	1	DECEMBE	R 13	,2000		
		1	O. Name and address	J. Chu	temp				Penn	Stre	et,	Baltimo	re, Mar	ylan	d 21201		
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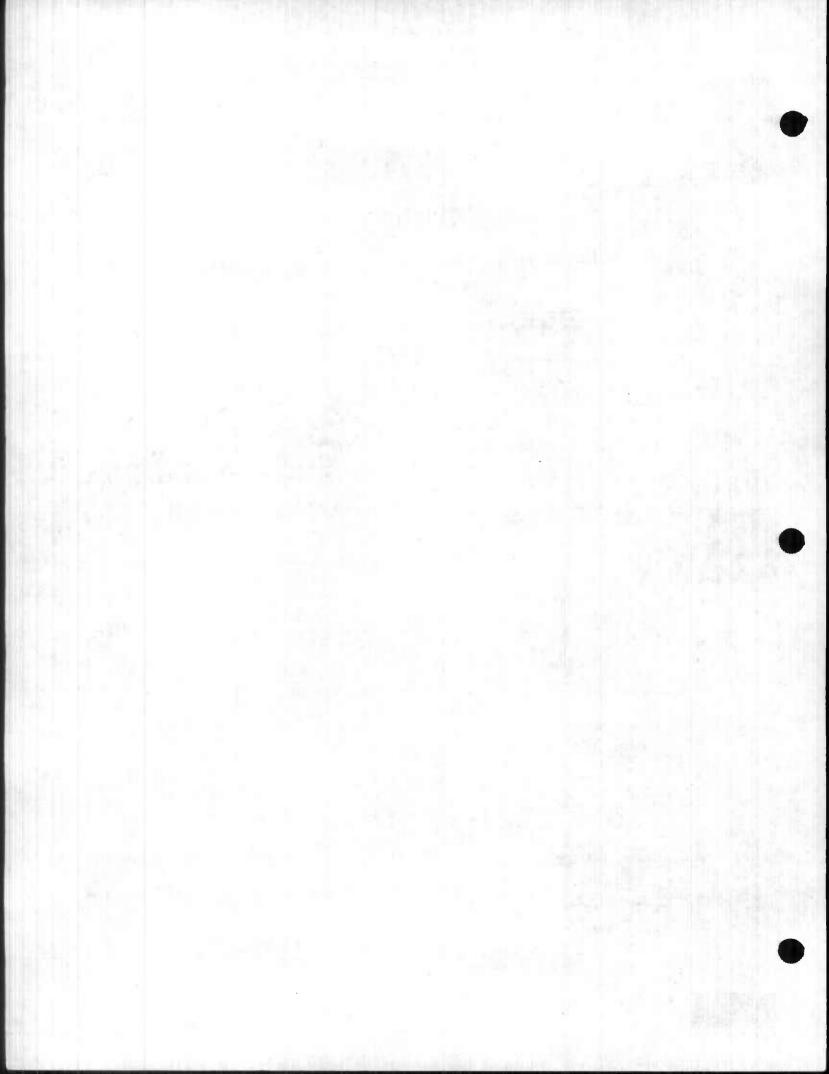
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene igcup igcup igcupCertificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day **Physician** Rances hoic 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Harbor Baltimore VIEW If Under 24 Hrs. ff Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foraign 5. Social Security Number **Funeral** Days Months 217-12-930 1 M 2 KF 78 Yrs. Director Usual Rasidance of Dacedani Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health end Mentel Hygiena and of Health end Mentel Hygiena and if if item 27 is marked other than "natural", or items 23s or 28s-f show any or other traumatic event, my Medical Examinar must be notified as 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Vas 2 □ No Director 10g, Citizen of Whet Country? 10a. Street and Number 10f. Zip Coda 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puerto Ricen, atc.) Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Race - Amaricen Indian Black, White, atc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yas 2 ⊠No If Yas, Giva Specify: White 1 Yas 2 No Specify: à 3 Wildowad 4 Divorced Year or Dates: Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry tuneral Elementary/Secondery (0-12) College (1-4or 5+) 10 18. Mother's Name (First, Middla, Maidan Sumama) 17. Father's Name (First, Middla, Last) Be nomas ase 2 19b. Mailing Address (Streat and Number of Flural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 20b. Place of Disposition (Nama of cemetary, cramatory or other place) Date 20a. Mathod of Disposition 20c. Location - City or Town, Stata permit. Peges
Department of
Important: If it
any injury or o an 1 Buriel 2 Cremation 3 Ramoval from Stata largy Valley Nem 4 □ Donation 5 □ Othar (Specify) 22. Nama and Addrass of Facility E VOILS 21, Signature of Funeral Service Licenses FUNCERO 234 Fart1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** 8 mos. /Medical Immediate Causa (Final disaasa or condition rasulting in death) Examiner Physician/Medical Examiner attending physician and for usa as the buriel-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Ceusa (Diseese or injury that initiated avants resulting in daath) Last Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to complation of ceusa of daath? 24a. Was an autopsy performed? After this certificate has I funerel director, page 2 s 2000 1 Yas 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was cese refarred to medical 26. Pleca of Daeth (Check only one) Hospital: Othar: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Othar (Specify) 2 1 Yas 2 40 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of Certification: 5 Panding Invastigation 1 Natural Injury To the Hospital or Attendit within 24 hours after death.
To the Funeral Diractor: At completely filled in by the fu 1 ☐ Yas 2 ☐ No after death. 2 Accident 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 6 Could not be 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and place, end dua to the ceuse(s) end menner es steted.

| Medical Examiner: On the best of axamination and/or invastigation, in my opinion, deeth occurred at the tima, data and place, and due to the cause(s) and mannar stated. 29a. Cartifier edicai 29c. Licansa number 29d. Data signed (Month. Day, Year) 29b. Signatura and titla of certifian 46389 malron January 30. Name and addrass of person who completed cause of death (Item 23e) (Type, Print) Baltimere MO STP 21202 31. Data filed (Month, Day, Year) 32. Registrar's Signatura JAN 05 Registrar

**ORIGINAL** 



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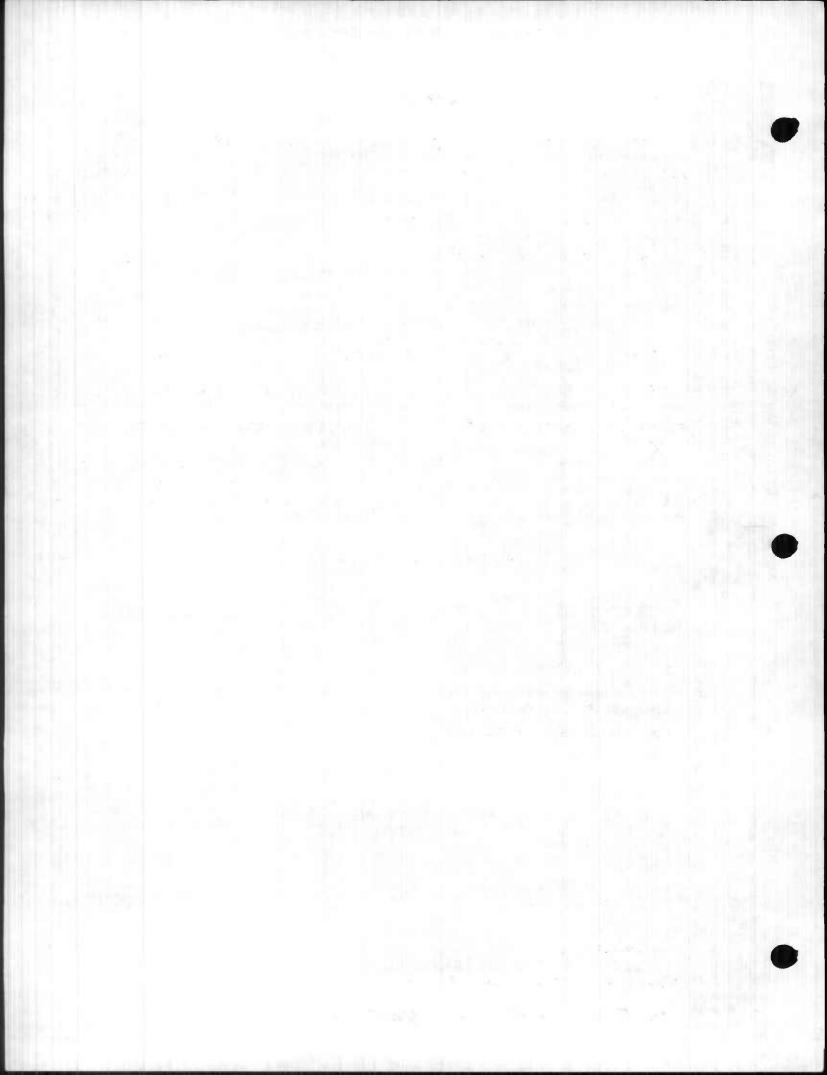
State of Maryland / Department of Health and Mental Hygiene 0 4 25 75

		Ce	rtificate o	f Death		Reg. No.				
1. Decedent's Name (First, Middle, Last) RUTH	FLANAG	AN			2. Date of De Month Duricema	Dey		ime of Death		
4a Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death					
	TAN HOSPITA		If Under 1 Ye		IMORE	N	/A	Chata F		
5. Social Security Number 6. Security Number 214-26-4443	7. Age (In yrs.	last birthday, Yrs.	Months Day		(Month Da	y, Year) 0,1916	9. Birthplece (S Country) VIRGIN	NIA		
10a. State 10b. County	10c. Ci	ity, Town or L	ocation				10d. fns	side City Limits		
MD. N/A		1)	Yes 2 No							
10e. Street and Number		ALTIM	10f. Zip Code	9		10g. Citizen of V	Vhat Country?			
5035 YELLOW	WOOD AVE.		21	209		U.S.	Α.			
	12. Was Decedent Ever in U	J,S. 13.		of Hispanic Origin? (Suban, Mexicen, Puer	specify Yes or No to Rican, etc.)		a - American Ind ck, White, etc.	lian,		
1 Never Married 2 Married  Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1□ Yes 2			Specify		CK		
15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Dece (Give	edent's Usuel Occ kind of work do	cupetion ne during most of wo	rking	16b. Kind of Bu	usiness/Industry			
Elementary/Secondery (0-12)	College (1-4or 5+)	life.	DO NOT use ret	ired)		DOMEGO	T.C.			
12th 17. Father's Name (First, Middle, Last)	N/A	HOME	MAKER	18. Mother's Na	me (First, Middle	DOMES				
	rc						-/			
ALEXANDER BATT  19e. Informant's Name/Relationship (Ty)		19h Mail	ing Address (Stre	DALSY eet end Number or R	WIL:		State Zin Code	)		
SUSANNA D.FLANAC 20a. Method of Disposition	AN-DAUGHTE 20b.	Place of Disp	osition (Name of	OWWOOD	AVE B	ALTO MI 20c. Location -	City or Town, Si	tate		
1 Burial 2 Cremation 3 R	lemoval from State	cemetery, cre	matory or other p	place)	1/5/00	O1 ADDI	ITHE ME			
Signature of Funeral Service License			MEM . P.	ARK CEM.						
A MI	GWYNN H									
4517 PARK HEIGHTS AVE BALTO . MD 212  239 Part Enter the disease, or complications that ceused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximation of the disease of the death in the disease of the disease										
shock, or heart failure. List only or	ne cause on each line.	ui. Do not er	itel trie friode of t	synig, addit as cardia	o or respiratory a	11031,	Interv	val Between		
Immediate Cause (Final			150000	m 1				1		
disease or condition resulting in death)	MYOUND			TON			1 4	day		
	Due to (	or as a conse	equence of):							
Sequentially list and disc.	Due to /	or as e conse	idilence of							
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	D09 to (	or as a corise	quellos oij.							
that initiated events	Due to (	or as a conse	quenca of):							
resulting in death) Last	220 10 (1		,							
	j									
Part II. Other significant conditions con	ntributing to death but not re-	sulting in the	underlying cause	given In Part I.	23b. Dld	tobecco uae co	ntribute to the c	ceuse of deeth		
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BACTERIAL EN										
STROKE	0001101113					en autopsy ormed?	available	topsy findings prior to		
3 ILUKE							completi of death	ion of ceuse		
					10	Yes 2000	1 ☐ Yes	20 No		
25. Wes case referred to medical				26. Place of De	ath (Check only	one)				
examiner?	lospitel: 1 Unpatient 2	ER/Outpetie	ent 3 DOA	Other: 4 Nursing I	Home 5 Resi	idence 6 DOth	er (Specify)			
27. Menner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	of 28c. In	njury at Vork?	28d. Describe	how injury occur	red			
2 Accident investigation		,,,,,,		☐Yes 2☐No						
3 Suicide 6 Could not be determined	28e. Place of Injury - At h	nome, farm, si	treet, factory, offi	се	28f. Location ( City or To	Street and Numb wn, State)	per or Rural Rou	te Number,		
	, , , , , , , , , , , , , , , , , , , ,									
29a. Certifier (Check only one) 1 Certifying Physical Continuous Check only one)	niclen: To the best of my knowner: On the besis of examine and manner stated.	owledge, deal etion end/or in	th occurred at the nvestigetion, in m	time, date and place y opinion, death occ	e, and due to the urred at the time,	cause(s) end ma date and place,	anner es stated. end due to the c	ceuse(s)		
29b. Signature and title of certifier	and mariner stated.					20d Data signs	d (Month Day )	Year)		
DI INVIIIN NI II	I MATA MID							000		
1	I WM MD		D	5135		DEMSE		000		
30. Name and address of person who co	moleted cause of death (Ite	m 23a) (Type	D					0000		
All reachers ()			29c. Lic	ense number		290. Date signe	d (month, Day,			

State

Registrar

JAN 0 5 2001



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Deta of Deeth 3. Time of Death **Physician** 29 2000 :25AM KULC /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore 10WSO If Under 24 Hrs. 8. Date of Birth (Month, Dey, If Under 1 Year 5. Sociel Security Number 7. Aga (In yrs. last birthday) 9. Birthplece (State or Foreign Country) **Funeral** -14-9074 1 M 2 F Months Deys Hours Min. 80 Yrs. Director Lennsylvania 40pil Usual Residence of Decedant with the Maryland 10a. Stete Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.

Ant. If Item 27 is marked other than "neturel", or items 23s or 28s-1 show ury or other treumedic event, the Medical Experience must be notified. 10b. County 10c. City, Town or Location 10d. inside City Limits HIMOR 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whef Country? Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1 Yes, 2 No If Yas, Giva Yaer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marifai Sfatus Black, Whita, atc. 1 ☐ Nevar Marriad 2 ☐ Merried Specify: Whit 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast greda completed) Elementery/Secondery (0-12) Coilege (1-4or 5+) ld 18. Mothar's Nema (First, Middle, Meiden Sumade) 17. Fethar's Name (First, Middle, Last) Be Benjamen 19e. Informant's Neme/Peletionship (Type, Print) 19b. Mailing Address (Street end Number or Paral Route Number, City or Town, Stete, Zip Code) y Foster RIC 30 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete important: If its any injury or oth anse 1 ☐ Buriel 2 Crametion 3 ☐ Ramovel from Stete EVANS FUNEPAR Chapal-Bolkie 4 ☐ Donetion 5 ☐ Other (Specify) 2000 22. Name and Address of Facility EVANS 21. Signature of Furtiral Service License6 unered Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical GI Bleed week Examiner Due to (or as a consequence of): Physician/Medical Examiner Esophageal months varices the ettending physician and hed for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e-consequence of): monthstoyea Circhosis Due to (or es a consequence of) Hepatitis years Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? been signed by I should be detach 1 Yss 2 No 3 Probably 4 Unknown Records. þ 24b. Were eutopsy findings available prior fo completion of cause of death? Completed 24a. Was en autopsy 6 this certificate has ral director, page 2 d 1 Yas 25 No 1 □ Yes 2 □ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, it 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) ER Hospitel: 1 inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 Yes 2 No 10 5 Residence 6 Dother (Specify) 0 28c. injury et Work? 27. Menner of Deeth 28a. Date of injury (Month, Dey Year) 28d. Describe how injury occurred Certification: Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 D Homicide fCortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier edical 29b. Signefure and fitta of certifier 29c. License number 29d. Date signed (Month, Dey, Year) ans D 51926 Dec 29 30. Neme and address of person who completed ceuse of deeth (item 23e) (Type, Print) M Gordon N. Charles St. Baltimore MD 21204 com 6601 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

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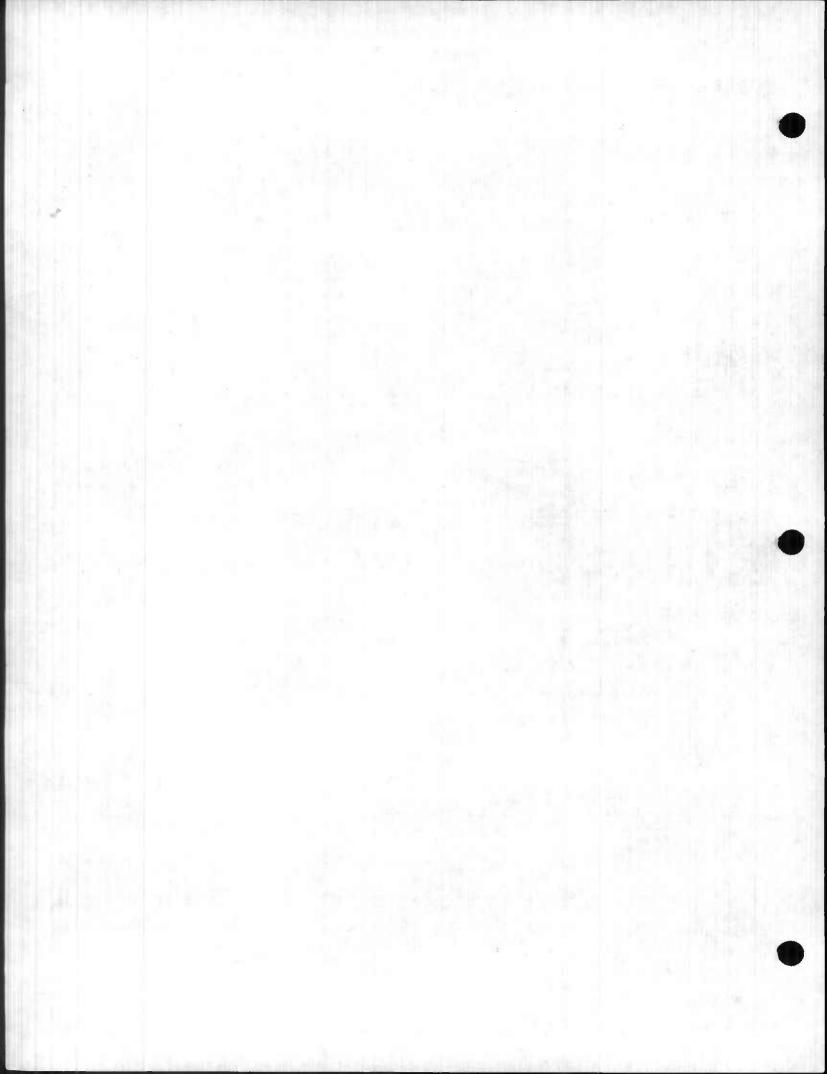
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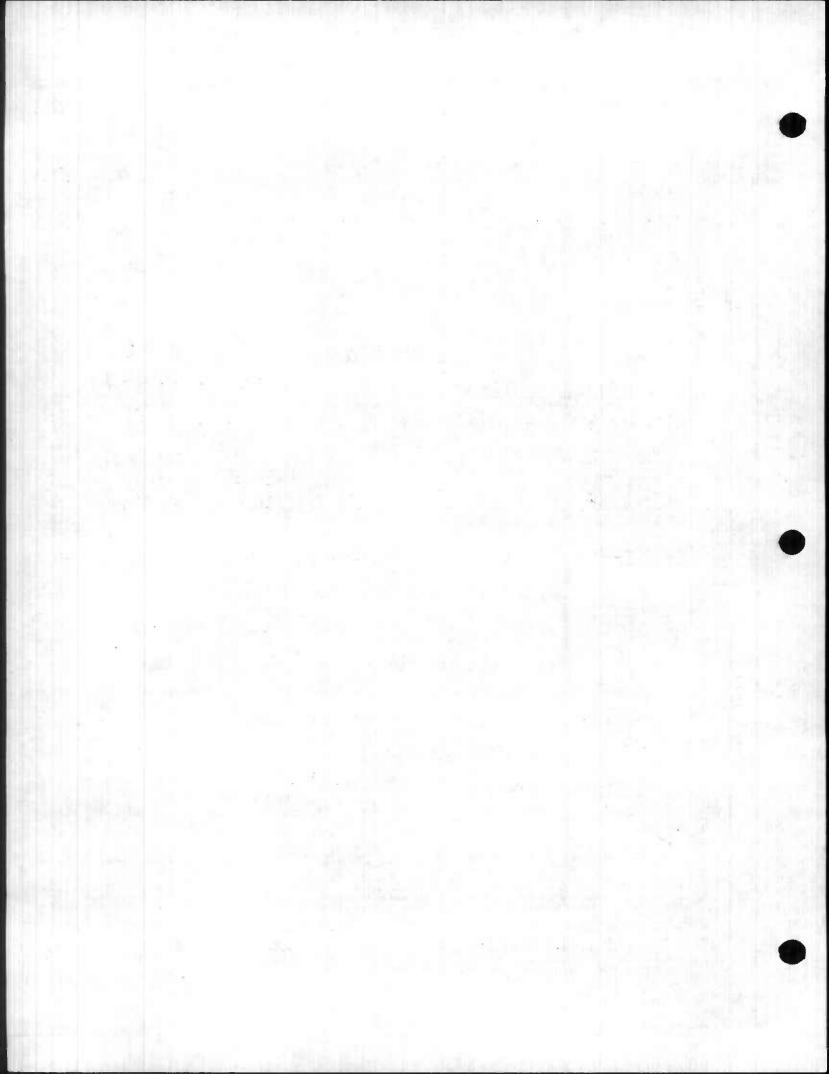
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			State of Maryland / Department of Health and Mi Certificate of Death		giene Reg. No.	
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Deta of De		3. Time of Death
	/Medic Examin	al	4a Facility Name (Innot Institution, giva street end number)  4b. City, Town, or Loc	cation of Death	3 2000 4c. County of De	) 5:04pm
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ı	Funeral Director		5. Social Sacurity Number 6. Sax 1 Months 1 Mont	8. Dete of Birt	y, Year) 9. B	irthplaca (Steta or Foreign
			Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location	Ang I		10d. Inside City Limits
	Maryle H sho	tor	Md Baltimore Baltimore			1 □ Yes 2 No
	vith the	Direc	10e. Street and Number 10f. Zip Code	M Dal	10g. Citizen of Whet C	Country?
	ler death with the Manylan Rems 23a or 28a-1 show	Funeral Director	11. Maritel Stetus 12. Was Decedent Evar in U.S. 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No		nerican Indian,
5-0036	a 9 2	þ	Armed Forces?  1 Nevar Married 2 Married 1 Yes, Specify Cuban, Mexican, Puèrio F 1 Yes, Give Yaar or Dates:  Armed Forces?  If Yes, specify Cuban, Mexican, Puèrio F 1 Yas 2 No Specify:	Rican, etc.)	Specify: U	ite, etc.
	d within 72 hours piena. r than "natural", r Madical En	Completed	15. Decedent's Education (Specify only highest grede complated)  16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired)	ng	16b. Kind of Busines	s/Industry
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Mar			19e. Informent's Name/Relationship (Type, Print)  19b. Mailing Address (Street end Number or Rure)	Route Number	or, City or Town, Stete	Zip (code)
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			Pert L Entar the disease, or complications that caused the death. Do not enter the mode of dying, such at diardiac or shock, or heart fellure. List only one cause on each line.	r raspiratory e	rest,	Approximate Intervel Between Onset end Death
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	To the within 2 To the comple	Me	29b. Signature and title of certifier  29c. License number		29d. Dete signed (Mo	nth, Day, Year)
	1/	,	- Walls, M.D F.ACE, D25886	)	JANUARU	. 2.2001
	A50		30. Name and eddress of person who completed/cause of deeth (Item 23e) (Type, Print).  A R O DOUDS 7505 CSCLR DR. TOUS	SON	Md 21	204
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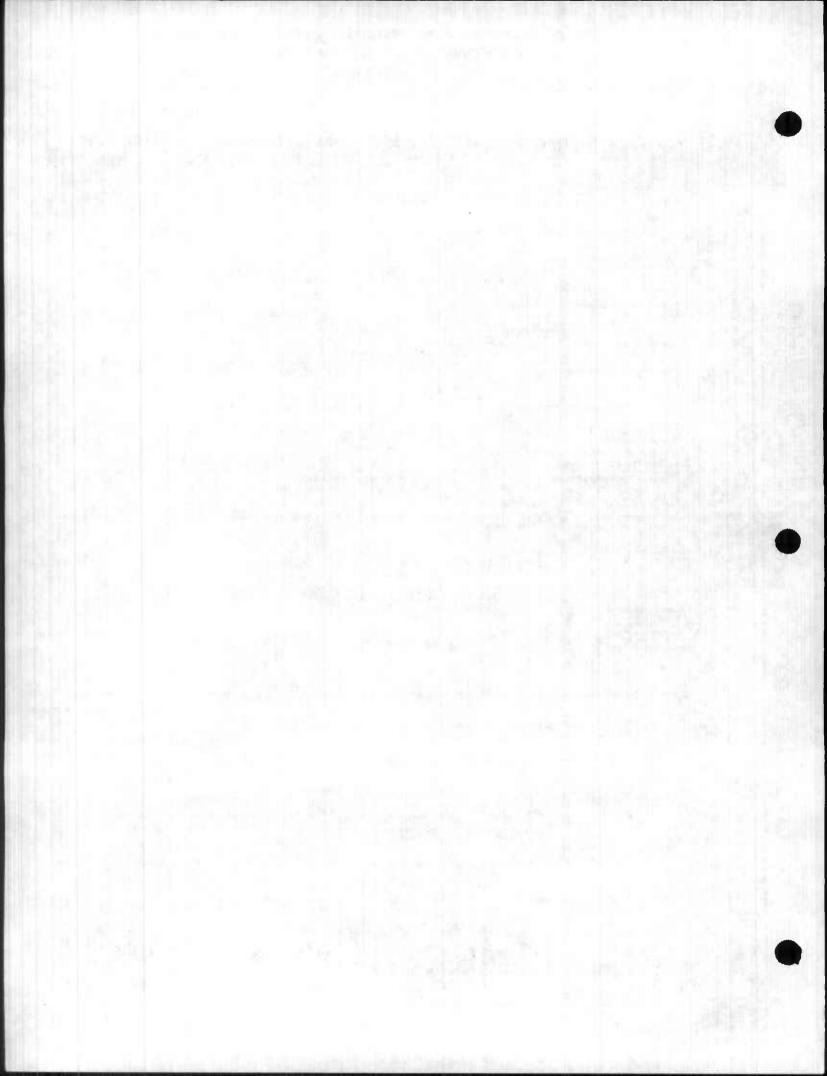


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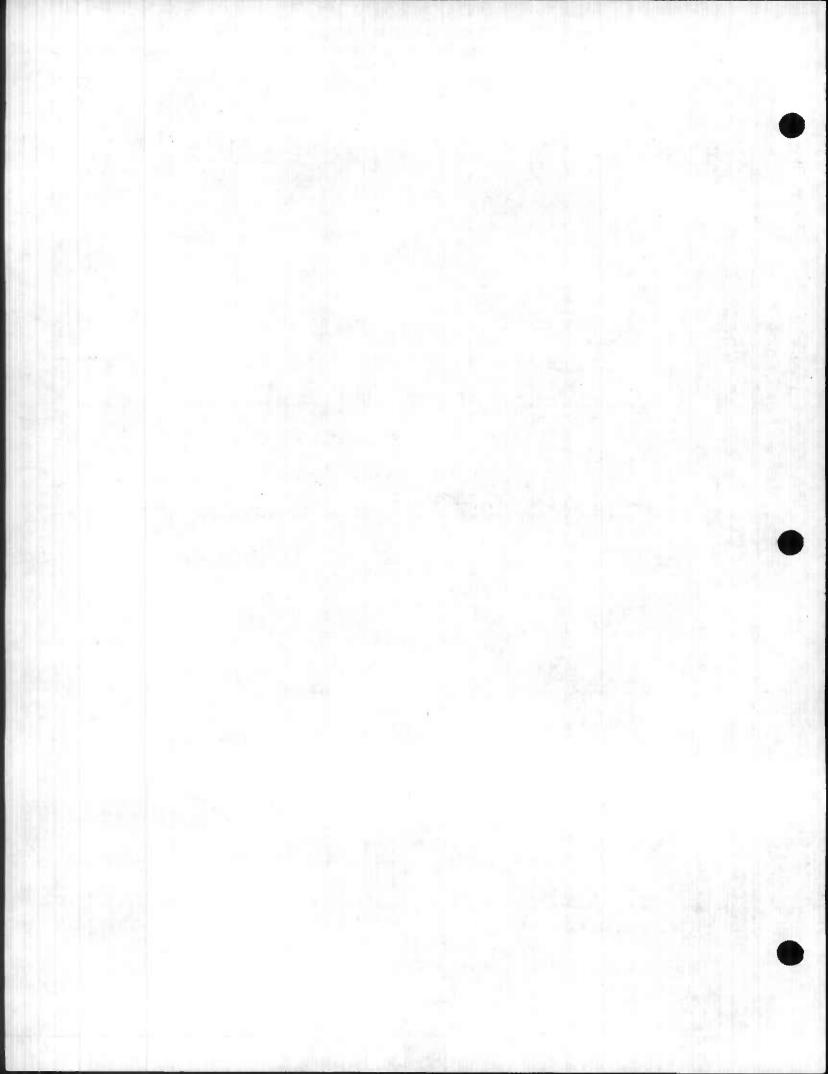
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 4257 Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Date of Death Month 3. Tima of Death Yaa **Physician** 9:40 pm JAMES O. HALSEY III 3000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel len Burnie Arundei G | EV | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluation | Evaluatio Hospital If Under 1 Year Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Months 1 MM 2□ F 225-57-2259 Yes 41 Apr 5, Virginia Director Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limita DC Washington 1 ☐ Yas 2X No Director 10g. Citizan of What Country? 10e. Street and Number 10f Zin Code 8 munt be "natural", or Items 23a 1114 Chicago Street 20020 Funeral IISA 12. Was Decedant Evar in U,S. Armed Forces? 1 Yas 2 No If Yas, Giva 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian Black, White, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify: Specify: black þ 3 Widowed 4 Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) Elementery/Secondary (0-12) Collega (1-4or 5+) 0 auto repairman automotive 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) 88 Mental ahould be h and Mental 7 is marked o James O. Halsey Jr Margaret Persinger 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. informant's Name/Ralationship (Type, Print) permit. Pages 1 and 2 at Department of Health and Important; if them 27 to m any injury or other traum once. Sue Ann Mack/sister 6886 Walker Mill Rd #101 Capitol Heights, MD 20b. Placa of Disposition (Nama of camatery, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☑ Othar (Specify) in state 21. Signatura of Funaral Service Licensee Ronal d S Wade, State Anatomy Board Director 655 W. Baltimore Street marie Moder Baltimore, MD 21201 23á. Part1. Enter the disease, of complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in deeth) /Medical Examiner Die to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-trans Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): certificate be execut Box 68760 Dua to (or as a consequence of): ed by the s Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yee 2 No 3 Probably 4 Unknown been signed by I should be detacl Division of Vital Records. à 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? The law page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No this certificate Physician: 25. Wes casa rafarred to medical Be 26. Placa of Beath (Check only one) Hoapital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No Certification: To 27. Manne of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of al or Attending P s after death. i Director: After ti d in by the funera 1 Watural 5 Panding Invastigation 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicida 6 Could not be 28e. Pleca of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 1 Cortifying Physician: To the best of my knowledge, deeth occurred at tha tima, deta and place, and due to the cause(s) end mannar as atted
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, data end place, end due to the cause(s) and mannar stated. 29a. Cartifiar edical 29c. Licansa number 29d. Data signad (Month, Day, Year) 29b. Signatura and titla of certified W 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) 479 Jungerstale Rd Severna Park Riedincer lenhiter 32. Registrar's Signatura State Registrar DHMH 16 Rev 6/95

**ORIGINAL** 



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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene []

Physician /Medical Examiner	

the Maryland r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

72 hours after death d 2 should be filed within 7: th and Mental Hygiene. 7 Is marked other than "n . Pages 1 and 2 should be fit ment of Haalth and Mental Hant: If Itam 27 is marked oth jury or other traumatic aven Baltimore, permit. Page Department of Important: If I any Injury or price.

**Physician** 

/Medical

Examiner

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After

that the death certificate be axecuted Box 68760 P.O. Records. law requires The Physician:

To the Mospital or Attending PI within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral State

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Dey DECEMBER 30 2000 Cora L. Holmes 1418 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE 2121 WINDSOR GARDEN LANE # 432 C If Under 24 Hrs. 5. Sociel Security Number If Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Dete of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 ☐ F Yrs Director 214-26-0987 75 10-01-25 NC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits X<sup>1</sup>√ Yes 2 No Director NA Baltimore Apt.C432 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 2121 Windsor Garden Lane 21207 IISA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S.
Armed Forces? 11 Marital Status Black White etc 1 ☐ Yes 2 ☐ No If Yes, GiveX X 1 Never Married 2 Married 1 Yes ≵ No Specify: Specify A 3 Widowed 4 □ Divorced Year or Dates: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Grade Dental Recptionist Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Williams Horace Claudia Lawrence 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 19e. Intorment's Name/Relationship (Type, Print) 5358 Sinclair Lane Apt. #6 Baltimore, MD Angelique Fields 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) King Mem. Pk. Cem. 01-05-01 Randallstown, MD 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licenses WM.C.March FH 1101 E. North Avenue 2 adi Wan 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in death) 8. Hypertensive Arterioselerotic Cardiovascular Disease
Due to (or as a consequence ot): Examiner Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or es e consequence ot): Physician/Medical Due to (or as a consequence of): resulting in death) Lest 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Nunknown by 24a. Wes an eutopsy performed? 24b. Were eutopsy findings available prior to Completed completion of ceuse of death? INSPECTION 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No 25. Wes case reterred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Scene Hospitel: P 1 XYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: 1 Vetural 5 Pending investigation 1 Tyes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es stated.

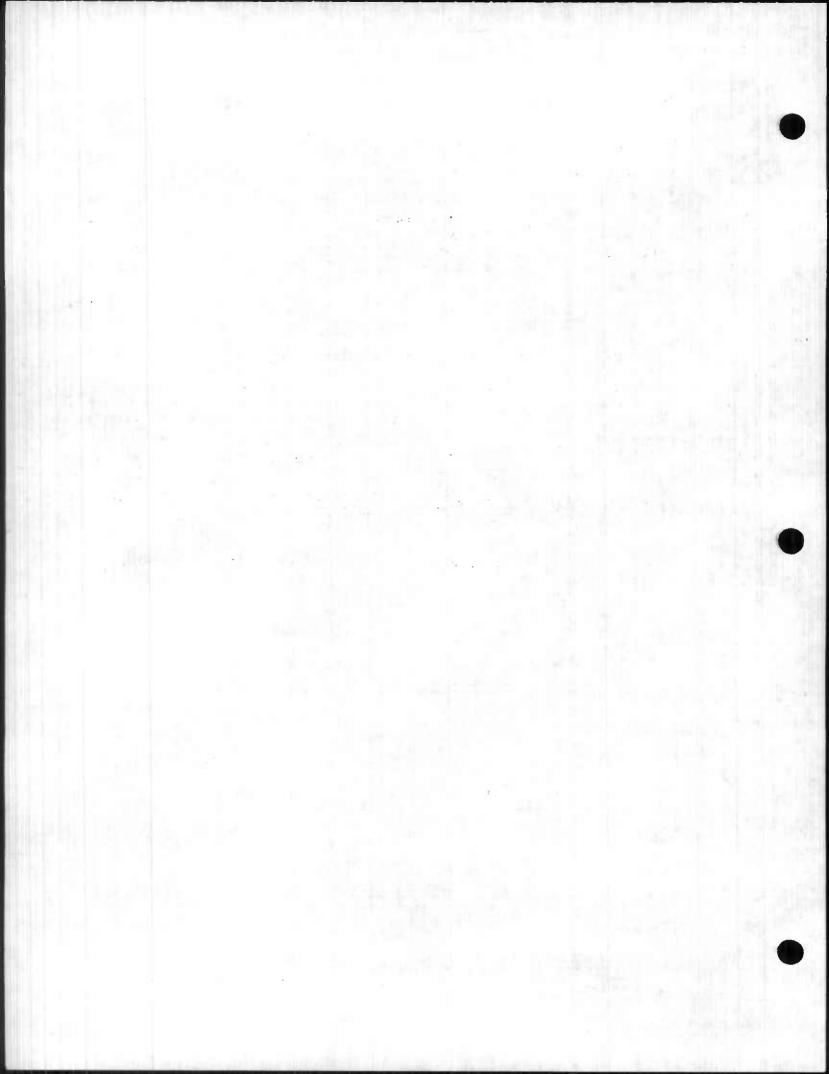
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier edical 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature end title of certifier O.C.M.E DECEMBER 31,2000 linton enne 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 ennis Chute mo 31. Dete filed (Month, Day, Year) 32. Registrar's Signature

Registrar

**DHMH 16 Rev 6/95** 

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Deeth 1. Decedent's Name (First, Middle, Last) MARJORIE HOWELI 4c. County of Death Facility Name (If not institution, give street and number) Town, or Location of Death N/A Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Sex 1□M 2XF Months Days Min 89 MARCH 25,191MARYLAND 081-26-7458 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2□No BALTIMORE MD. N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A.

14. Race - American Indian, STREET 21217 1000 MOSHER 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1, Never Merried 2 Married 1 Yes 2 No Specify 3 Widowed 4 □ Divorced BLACK 16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) 12th BEAUTICIAN SOLE PROPRIETORSHIP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ARTHUR WILLIAMS NELLIE PAYNE 19a. Informant's Name/Relationship (Type, Print) 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUCILLE RHEUBOTTOM-SISTER BALTIMORE, MD. 21207 6713 ALTER STREET 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) **METRO** CREMATORY 12/27/00 CATONSVILLE, MD. 21. Signature of Funeral Service License 22. Name and Address of Facility LEWIS T. GWYNN LEWIS T.GWYNN FUNERAL HOME Swynen 4517 PARKHEIGHTS AVE. BALTO. MD. 21215-6393 Approximate Interval Between Onset end Death 23a. Pent1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final diseese or condition resulting in deeth) Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Was en eutopsy 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medical examiner? 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

**Physician** P.O. of Vital Records, Division

Examiner Physician/Medical Examiner The law requires that the death certificate be executed the burial-trer USB 85 à 90 Be Completed page 2 should or Attending Physician: after death.

Director: After this certified in by the funerel director. Medical Certification: To filled in by To the Hospital o within 24 hours af To the Funeral Di

**Physician** 

/Medical

Examiner

10e. State

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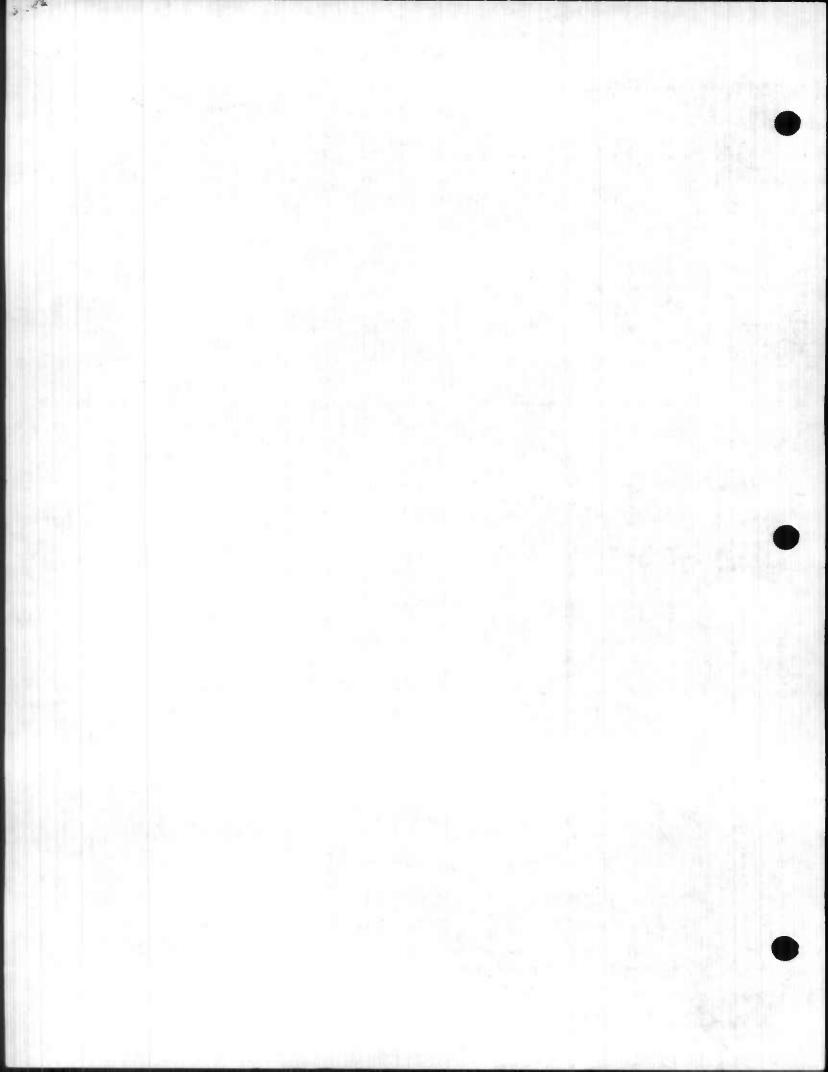
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27. Menner of Death 1 Maturat 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number of serson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 0 5 2001

Registrar

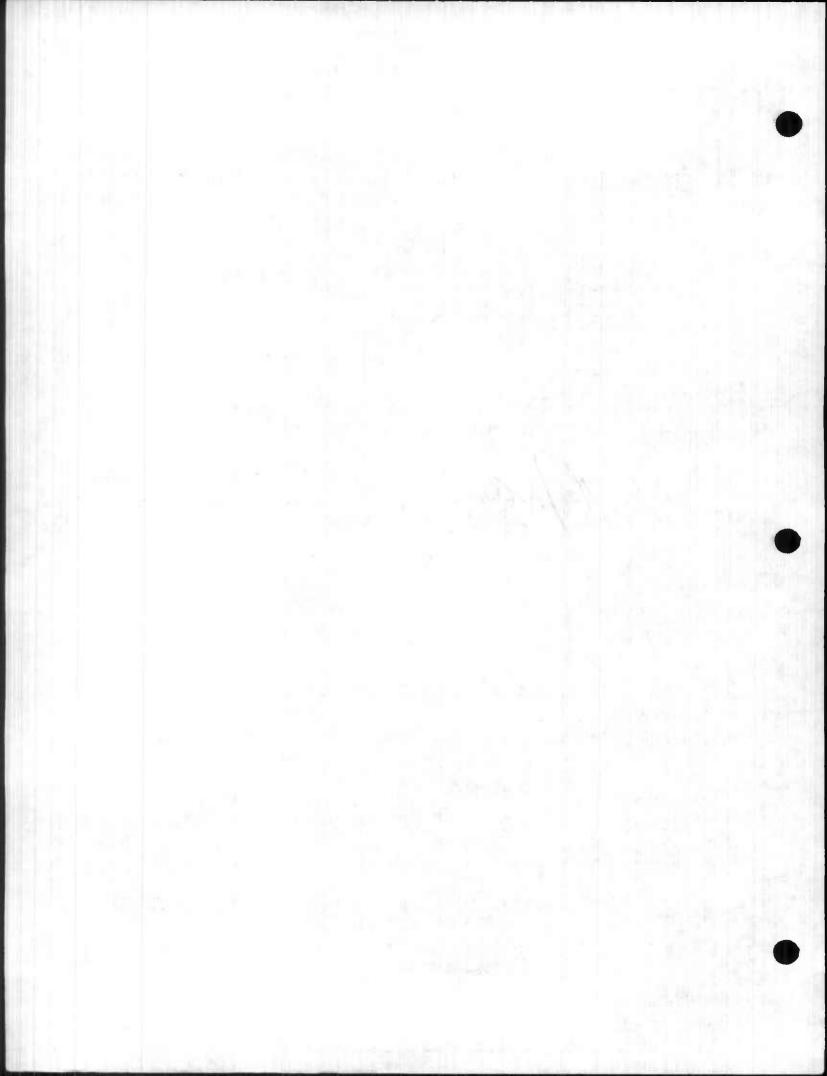
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State of Maryland / Department of Health and Mental Hygiene 00 42582

	Certificate of Death	Reg. No.							
	1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day	3. Tima of Death						
Physician /Medical	Dorothy Hill	December 28	2000 12:20 PM						
Examiner	4a Facility Name (It not institution, give street and number)  4b. City, Town, or Loc  Nation Memorial Hospital  Baltimo	cation of Death 4c. County	of Death						
Funeral	A COUNTY OF THE PARTY OF THE PA	8. Date of Birth	9. Birthplaca (Stata or Foreign						
Director	231-36-4078 1 M 2 F 7/ Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	New York						
fland	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits						
with the Mary n or 28s-f sh be notified.	mo Baltimore	40- 62541	1 □ ves 2 □ No						
th with the 23a or 2	10e. Street and Number 10f. Zip Code 212/8	10g. Citizen of N	SA						
5-0020 72 hours effer death with the Maryland naturel; or frems 23s or 28s-f show size! Examiner must be notified asted by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Forces?  1 □ Yes 2 □ No Specify:	city Yes or No- Rican, etc.) 14. Rac Blac Specify	e-American Indian, ck, White, atc.						
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should and Men marks umartic	19a. Informant's Name/Relationship (Type, Print)  19b. Malling Addrass (Street end Number or Rure	I Route Number, City or Town,	State, Zip Code)						
	Calvin N. Hill TR-SON 345 E. 28thst. Ba	Himore many	land 21218						
Thealth	20a. Method of Disposition 20b. Place of Disposition (Nama of		City or Town, State						
Baltimore peemit, Pages 1 Department of H Important, if han any injury or oth once.	1 Burial 2 Commation 3 Demoval from State 4 Donation 5 Donar (Society)  21. Signature of Furbral Server Command  22. Name and Address of Facility  All Dels Meth	13/01 Balt	mere mary land						
ACCUPATION.	23a. Part. Enter the clease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o	r respiratory arrast,	Approximate Interval Between						
Physicia'n	and the state of t		Onset and Death						
/Medical	Immediate Ceuse (Final disease or condition Hunerhenson		754 RS.						
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v requ		24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?						
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f Vital Revision: The lay scentificate has director, page 2	25. Was case referred to medical 26. Place of Death	(Check only one)	1						
Of Vita Physicien: this certific ral director.	Hospital: V	me 5 Residenca 6 Ott	nar (Specify)						
E 5 5 6	27. Manner of Death 1 Polatural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 No Year 2 No	28d. Describe how injury occur	rred						
Division o To the Hospital or Attending Ph within 24 hours after death To the Funeral Director: After th completely filled in by the funeral Medical Certification:	all a little Could get be	281. Location (Street and Num. City or Town, Stete)	ber or Rurel Route Number,						
he Hospital in 24 hours he Funeral i pletely filled edical Ce	29a. Certifier  (Check only   Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, e  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred								
the H thin 24 the F mplet	one) and mannar stated.								
5 t ¥ t oo	29b. Signature and title of contifier W.D. 29c. License number D0053641	Janua Janua	Mary 4 2001						
7	30. Name and address of person with completed gruse of deeth (Item 23a) (Type, Print)  4 Th Floor  31. Date filed (Month, Dey, Year)  32. Registrar's Signature	202 Miche	lle Juaneta						
State Registrar	31. Date filed (Month, Dey, Year)  32. Registrar's Signature  Analysis Anal	14	100						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#25 perPHYG791 1/16/2001 EW Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 3 Time of Deeth **Physician** ARMENUE JACKSON 10:10 25 00 pm /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** CATONSVILLE CATONSVILLE COMMONS Baltimore 5. Sociel Security Number If Under 1 Year | if Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplece (Stete or Foreign Country) North Carolina **Funeral** 1□M 20 F Deys 216-34-5414 Months Hours 60 Director Usuel Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Experient must be notified at 10d. Inside City Limits Baltimore Catonsville Director 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21228 USA 16 Fursting Avenue Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ② No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 14. Race - American Indian, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours efter 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: specify: black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) handcrafts self employed other treumatic event. Baltimore, Maryland 17. Fether's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Heelth and Mental Hy Important; if Item 27 is marked othen 9 injury or other treumatic eventence. 18. Mother's Neme (First, Middle, Meiden Surneme) Be Roy Byers Iola Powell 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Rosa Douglas/sister 1915 E. Chase Street Baltimore, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removal from State 4 Donetion 5 Other (Specify) in state 21. Signature of Funeral Service Licensee
Royald S. Wade Virector 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Made Baltimore, MD minul 21201 23a. Perd. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final pritoneal Cucinoma with metastasis disease or condition resulting in death) **Examiner** Due to (or es e consequence of Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last pue the buriel-tran Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): signed by the et Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Tinknown pleural Division of Vital Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed this certificete has 1 Yes 2 No 1 ☐ Yes 2 ☐ No al or Attending Physician: The safter death.
I Director: After this certificated in by the funeral director, pa 25. Was cese referred to medicel examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manney of Deeth 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No To the Hospital or Attervithin 24 hours efter der To the Funeral Director completely filled in by the 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated. Medicai 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) D27569 iho 1-02-01

R. HETTLEMAN, M.D., 1838 GREENE TREE RD., PIKESVILLE, MD. 21208

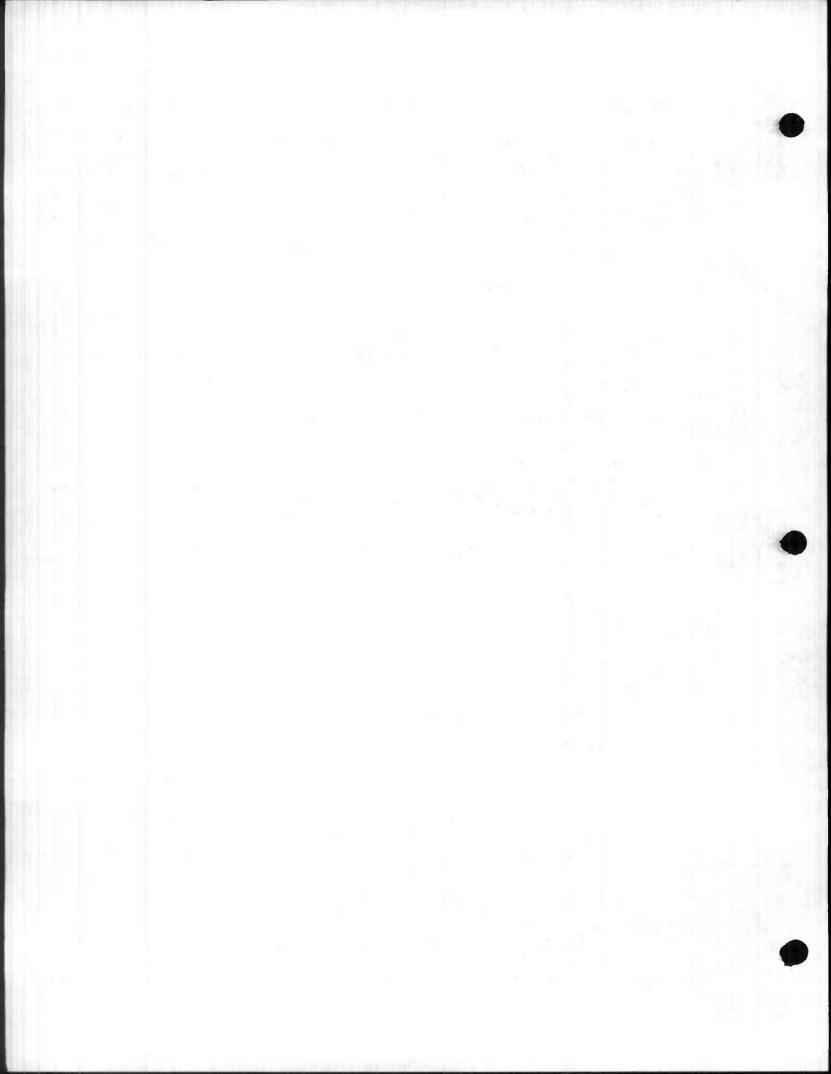
Registrar

State

31. Date filed (Month,

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signeture



### Please Type or Print in Biack Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Thelma Johnson December 31,2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Baltimore Hospital (Salt more 81 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) 6 Sax 10 M 20 F Months 220-20-6860 MD 26/1925 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Brook 1 Yes 2 No MD 10a. Street and Number 10f. Zip/Code 10g. Citizen of What Country? USA 21325 CORPIN 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Specify: Black 1□ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratirad) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) House Wilre Home MAKer 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Estele Ham CPPS Joe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, P (Daughter) 653 Balto MD 21229 QUEEnsgate Rd Denise 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Memo 1-5-01 Balto mo 4 □ Donation 5 □ Other (Specify) 108 W. Northave 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Tri-State F Balto MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 6-7 days Immediate Cause (Final disease or condition resulting in death) ardiogenic Due to (or es a consequence of) Dronam arter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Acute renal Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 NNo 1 ☐ Yes 2 No 1 Yes

Physician /Medical Examiner

Examiner

Physician/Medical

by

Completed

Be

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Certification:

29a. Certifier (Check only one)

**Physician** 

/Medical

**Examiner** 

10a State

Director

Funeral

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Completed

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**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the lead call Examinat must be notined at

of the state of th

permit. Peges 1 end 2 should be file Department of Heelth and Mentel Hy Important: If Item 27 is marked oths any Injury or other treumatic event

Baltimore, Maryland 21215-0020

attanding physician and for use as the bunal-trans signed by

Box 68760

Division of Vital Records, P.O.

After this Ne Hospital or Attending Pin 24 hours after death.

Funerel Director: After the

within 2. State Registra

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Neturel 28b. Time of 28d. Describe how Injury occurred Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homicide

12 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

RES-00

MD

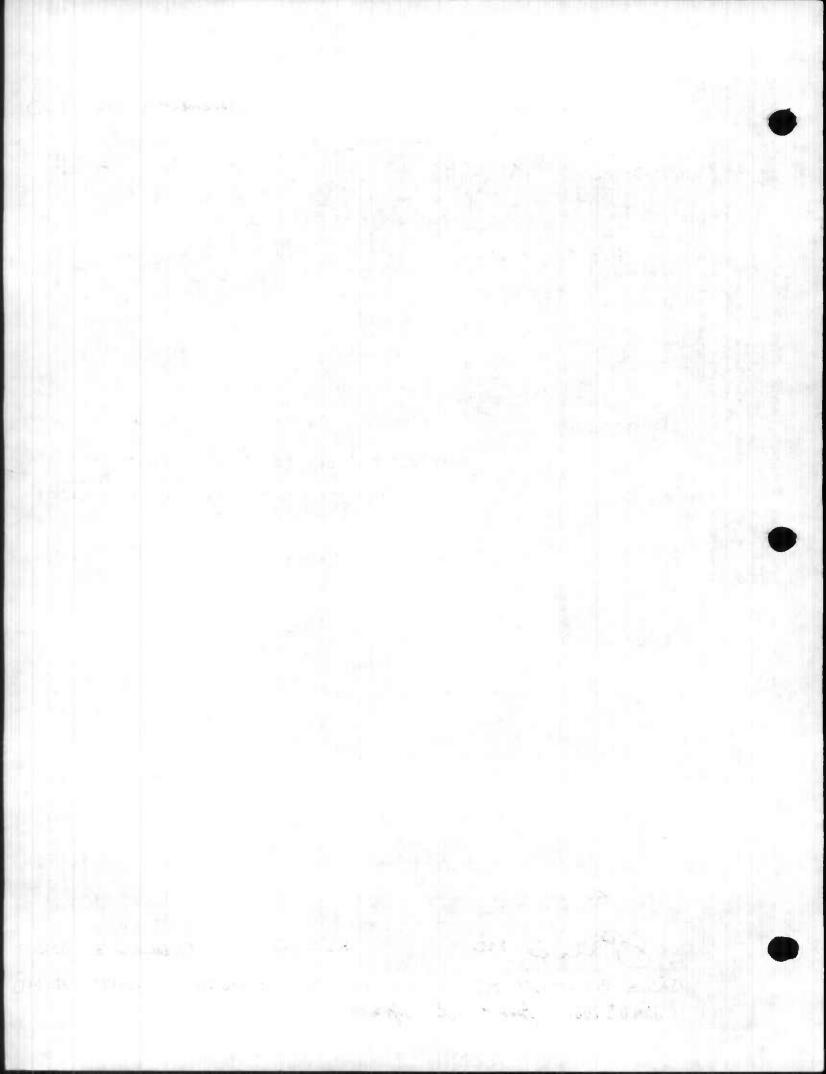
HOSPITAL OF BALTIMORE, BALTIMORE MD

December 31, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

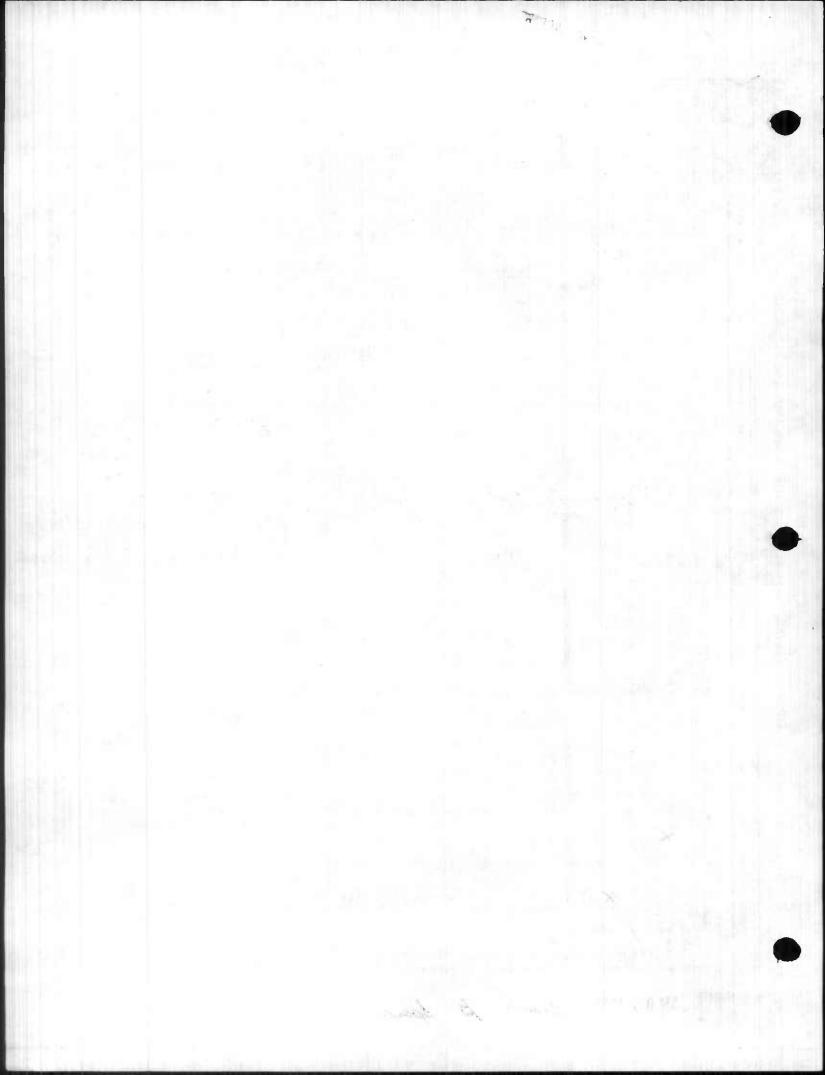
BUCHOUSKI SINAI JACOB MD; 31. Date filed (Month, Day, Year JAN 0 5 200

32. Registrar's Signature



### Please Type or Print in Black indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Barbara Ann McFadden December 30, 2000 2:35am /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1125 North Patterson Park Avenue Apt.205 Baltimore N/A 5. Social Security Number If Under 1 Yeer Months Days 8. Date of Birth (Month, Day Year) 9. Birthplace (State or Foreign Sept 15, 1954 S. Carolina 7. Age (In yrs. last birthdey) If Under 24 Hrs. **Funeral** Hours 1 M 2 F 46 Director 218-60-3291 Usual Residence of Decedent the Maryland 10d. Inside City Limits r 28a-f ahow 10a. Stete 10b. County 10c. City. Town or Location Yes 2 No MD. N/A Director Baltimore 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 205 ma 23a or 8 death with 1125 North Patterson Park Avenue 21213 TISA Funeral Roma: 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter filed within 72 hours after 1 ☐ Yes 2 ☐ XNo If Yes, Give 1 Never Married 2 Married 21215-0020 Specify: Black 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Cashier Goodwill Industries Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fill ment of Health end Mental Hant: If itam 27 is marked oth jury or other traumatic even Be Robert McFadden Sara Gregg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 19a. Informant's Name/Relationship (Type, Print) DaShawn R. Coleman (Daughter) 1125 N. Patterson Park Ave. Apt. 205 Balto, MD. 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 1/03/01 Voshell's Mem Grds Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Caple Funeral Service 5502 Winner Avenue Baltimore, Maryland 21215 23a. Pert1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death ) Physician /Medical Immediate Cause (Finel diseese or condition resulting in death) 462R Examiner Due to (or as a consequenca of) Examiner The lew requires that the death certificate be axecuted bunal-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): physician a the bunal Box 68760 Physician/Medical Due to (or as e consequenca of) 88 980 signed by the a Part II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? page 2 s hes 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ₽ No certificate Division of Vital or Attending Physicien: director. 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this is 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 Tyes 2 □ No within 24 hours after death. To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. edicai 29a. Certifier completely (Check only one) 흥 29b. Signature and tipe of dertifier 29c. License number 29d./Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Dr. Arnel Tagle M.D. 315 N. Calvert Street Baltimore, Maryland 21202 32. Registrar's Signature State Registrar

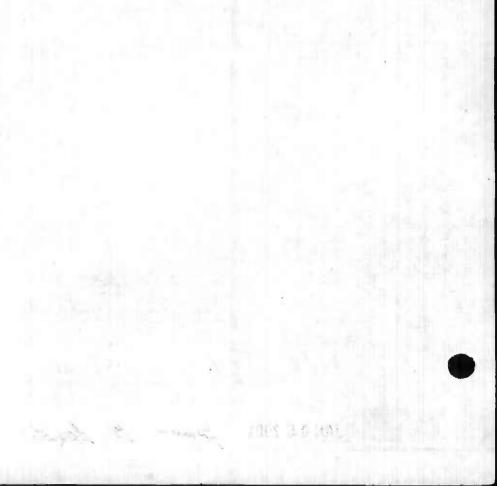


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-4	noir Malone MS# 23a & 27 per ME G792 1. Decedent's Nama (First, Middle, Last		Certifica			2. Data of Dea	eg. No.		3. Tima of Death
Physician /Medical Examiner	SHIRLEY LENOIR 4s Facility Name (If not institution, give	4b. City, Town, or Lo	Month Decembe	Day 14, 2		9:45 A.M.			
Funeral Director	218-30-6726		lest birthday) If Und Month	der 1 Year is Days	Pikesvil  If Undar 24 Hrs.  Hours Min.	8. Data of Birth (Month, Day 05-03-		9. Birthplace Country) ASHL	e (State or Foreign
ahow Mari	Usual Residence of Decedent  10a. State 10b. County		y, Town or Location						Inside City Limits 1 ★Yes 2 No
or 28a-f	MD N/A 10e. Street and Number	В	ALTIMORE 101.	Zip Code		1	0g. Citizan of V		41
s 1 and 2 should be filed within 72 hours after death with the Meryland Heelth and Mental Hygiene. Heelth and Mental Hygiene. other traumatic event, the Medical Examine must be notified at the To Be Completed by Funeral Director		RD  12. Was Decedent Ever in U. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1111		dispanIc Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		a - American i k, White, etc.	
be filed within 72 hours than "natural d'other than "natural avent, tra Modical Be Completed	15. Decedent's Edu (Specify only highest grad Elamentary/Secondery (0-12) 1. 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  HOUSESELF				16b. Kind of Business/Industry  SELF EMPLOYE		
should be fill and Mental H marked off umartic even	17. Father's Name (First, Middle, Last) PAUL SMITH				18. Mother's Name EVA SM1	СТН			
00	19a. Informant's Name/Ralationship (7)  SHAWN MALONE  20a. Method of Disposition  1 □ Burial 2 ☆ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	20b. P. Removal from State		RKEY Varna of or other pla		WESTN Date		R MD City or Town,	21158
pernit. Pages 1 at Depertment of Heel Important: if Item: any Injury or othe page.	21. Signature of Funeral Service Licens  Willie Elff	ass of Facility UNERAL BERTY HGE	HOME	E, BAL'		D 21207			
Physician /Medical Examiner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Finel disease or condition resulting in deeth)	NASAL CANCER	n. Do not enter tha m		ng, such as cardiac (	or respiretory arr	est,	As int	oproximate tarvel Between nsat and Death
death certificate be executed e ettending physicien and ad for use as the burial-transit siclan/Medical Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last	c	r as a consequenca o						
res thet the death certification of the detection of the death of the de	Part tt. Other significant conditions con	ntributing to death but not res	ulting in the underlyin	g cause gi	ven in Part I.		obacco use con		e causs of death?
aw requi						24a. Was a perfor	med?	avalla	
hysician: his certifical director	25. Was casa referred to medical examiner?  1 \( \sum_{Y} \text{Yes}  2 \subseteq \text{No} \)  27. Manner of Death  1 \( \sum_{Y} \text{Naturel}  5 \subseteq \text{Pending}  \text{investigation} \)	Hospitel: 1 Inpatient 2 Inpatient 2 Asa. Date of Injury (Month, Dey Year)	ER/Outpatient 3 28b. Time of Injury	26. Placa of Death (Check only DOA Other: 4 Nursing Homa 5 Re 28c. Injury at Work?			,		
Hospital or Attending P 24 hours effer deeth. Funeral Director: Affert stely filled in by the funeral dical Certification:	3 Suicide 6 Could not be datarmined	28a. Pleca of Injury - At he building, etc. (Specification: To the best of my known		28f. Location (S City or Tow	n, Stete)	716			
To the Hospital within 24 hours e To the Funeral L completely filled Medical Ce		slcian: To the best of my kno ner: On the basis of examine and mannar stated.	tion and/or investiget	ion, in my o		red at the time, o		and dua to the	y, Year)
State	30. Name and address of person who could be seen and address of person who could be seen and	ompleted causa of daath (Item)  adentz  32. Registrar's Signa	111 Pe	enn S	treet, Bal	ltimore,	Maryla	and 212	201

**ORIGINAL** 



State

**DHMH 16 Rev 6/95** 

Registrar

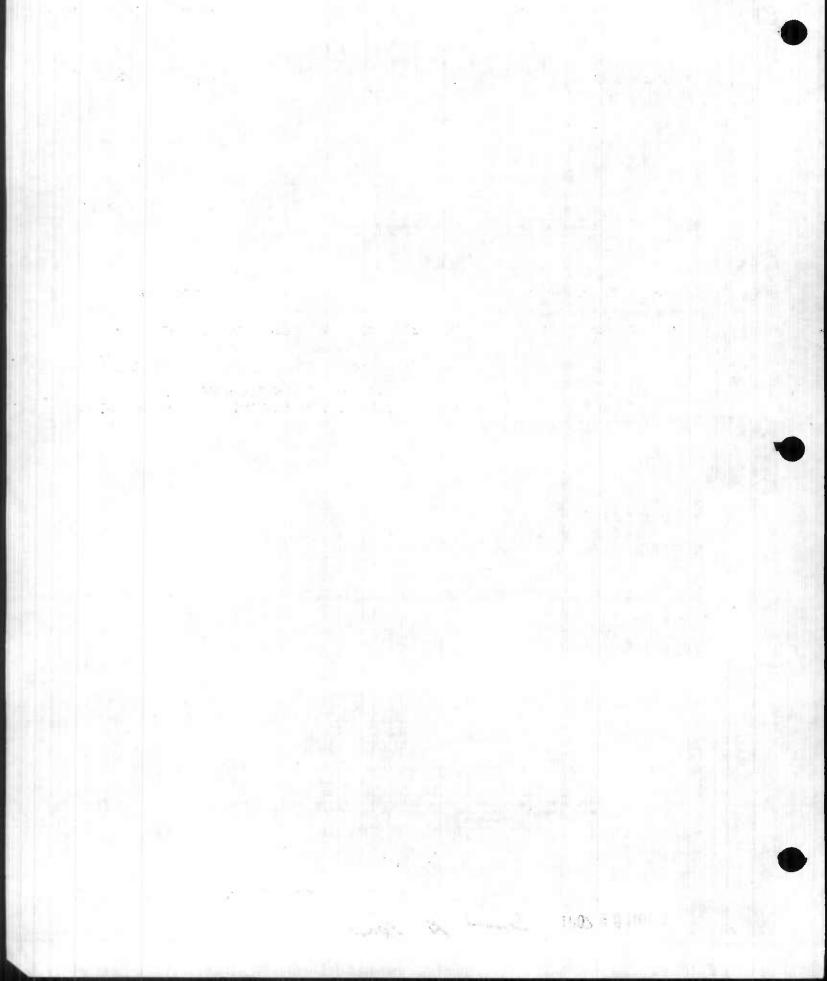
Stronen S.
31. Date filed (Month, Dey, Year)
JAN 0 5 2001 Radentz

32. Registrer's Signetura

Sports

ORIGINAL

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 11:25 1 BETTY V **MELKA** 2000 December 28 /Medical 4b, City, Town, or Location of Death 4a Facility Nema (If not institution, giva street and number) 4c. County of Death Examiner uare If Under 1 Yaar move bita If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 24 192 5. Social Security Number 7. Age (In yrs. last birthdey) 6 Sax Birthplace (State or Foreign Country) **Funeral** Montha Deys Hours 1□M 2QF 212-20-7506 76 MAryland May Director Usual Residence of Decedent the Meryland Peges 1 and 2 should be filed within 72 hours after death with the Merylen nent of Heelth end Mentel Hygiene.

ant: If item 27 is marked other than "natural; or itema 23s or 28s-f show ury or other treumatic event, the Medical Exempter must be notified. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Essex 1 Yea 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Riverside Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yas 2 ∑ No If Yes, Give Yaer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Stetus Bleck, White, etc. 1 Nevar Married 2 Married 1 Yes 2₺ No Specify: White p 3℃Vidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Nama (First, Middla, Last) permit. Peges 1 and 2 should be f. Department of Heelth and Mental P Important: if them 27 is marked out eny Injury or other treumatic even page. Be Ora Clark George Walton 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Melka / son 2311 Aquilas Delight Fallston MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place)

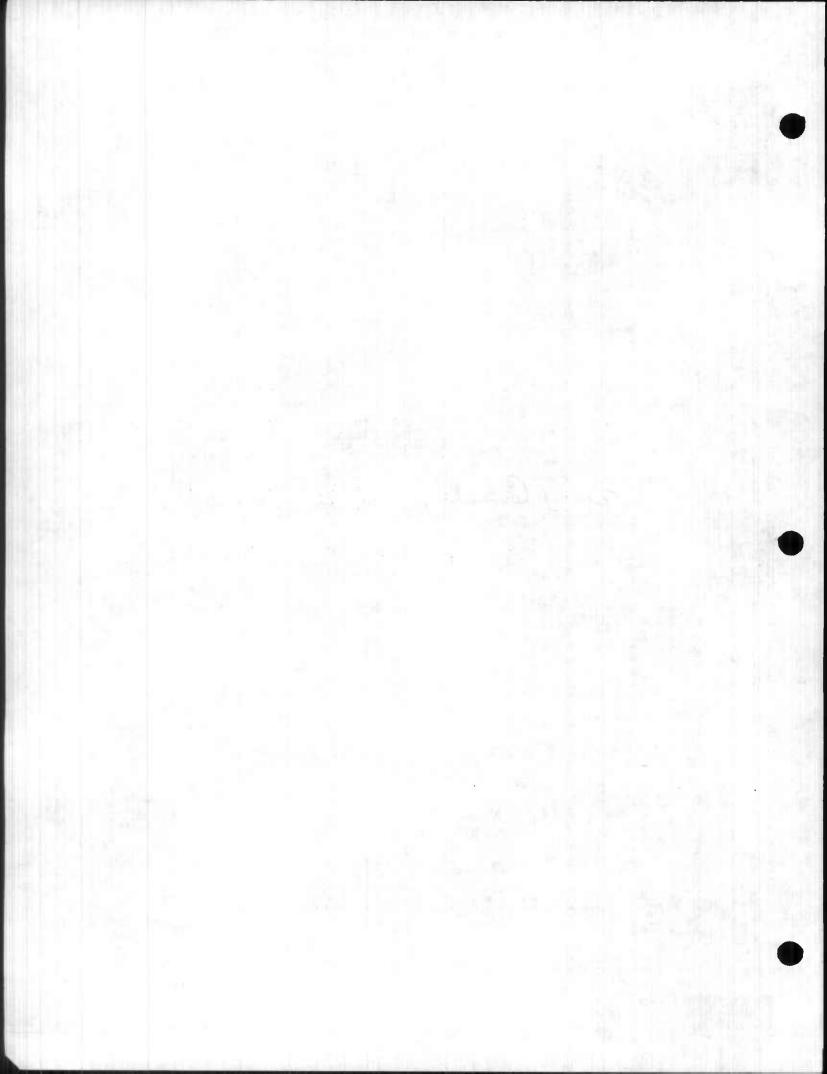
Holy Redeemer Cemetery 1/2/01 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Ramovel from State Balitmore MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Sarvice Licensee 22. Name end Address of Fecility Connelly Funeral Home of Essex 300 MAce AVe. Baltimore Md. 21221 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Betw Onset and Death **Physician** Immediata Causa (Final disaesa or condition resulting in deeth) /Medical nav Examiner Due to (o) es e consequenca of): Examiner lonio attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated events resulting in death) Lest Due to (or es a consequença of): ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Ves 2 No 3 Probably 4 Unknown sease by page 2 should b 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed Mellitus 1 Yes 1 ☐ Yes 2 ☐ No certificate labetes 25. Wes cese referred to medical exeminer? Physician: Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 27. Megner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury et Work? i or Attending Patter deeth. After 5 Pending investigation 1 Neturel after deeth.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital owithin 24 hours a To the Funerel D TSC Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. 29e. Certifier edical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of padillies D0055331 28/2000 - MD 2/23 30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print) 9000 Frank William Warren Populare Drive Maryland 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State **JAN 0 5** Registrar

DHMH 16 Rev 6/95

ORIGINAL



Records, P.O.

ROY MOLICK

The lew requires that the deeth certificate be axecuted Box 68760. Division of Vital Physicien:

the Maryland

with

deeth

72 hours after

a.m.

2000

31,

DECEMBER

Baltimore,

State Registrar

**DHMH 16 Rev 6/95** 

edical

29a. Certifier (Check only one)

DR. TARIQ MAHMOOD

29b. Signature and title of certifier

2300 DULANEY VALLEY RD. 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated.

29c. License number

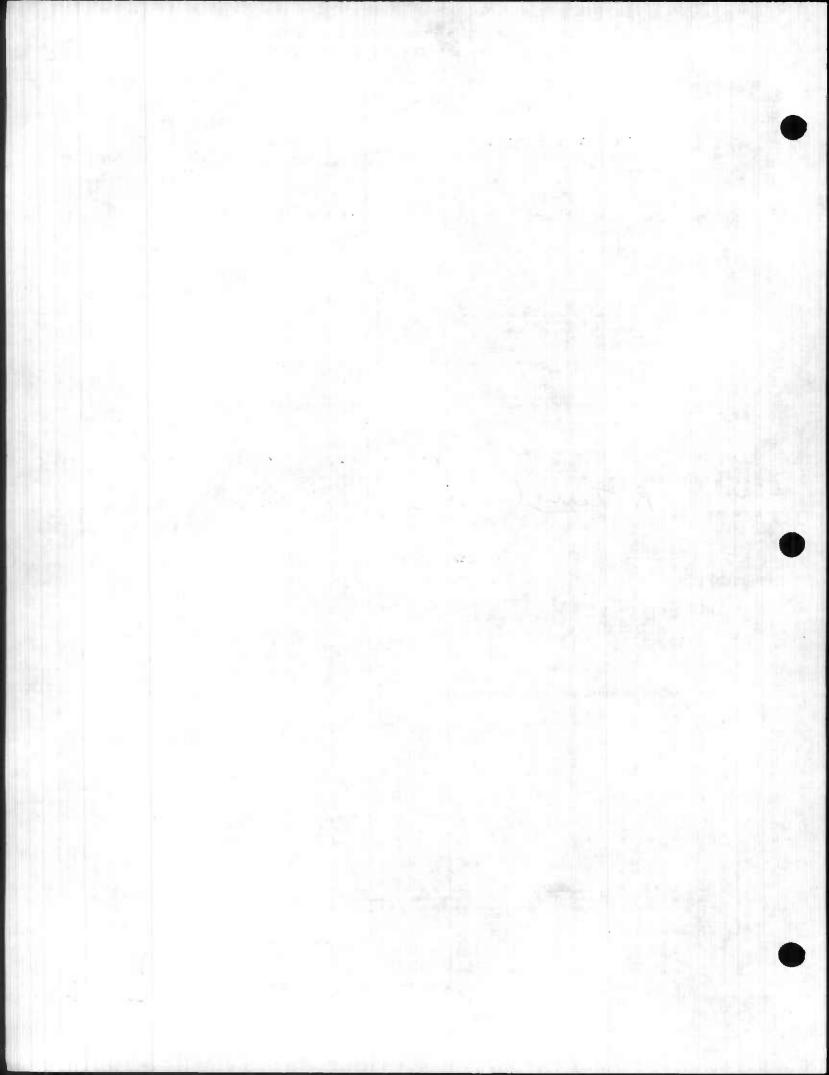
1)43725

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



CPS 00-7534-025 UNKNOWN 00-358

ease Type or Print in Black Indelible Ink. Assure Al	il Copies Are Legible.
State of Maryland / Department of Health and N	Mental Hygiene 0 42590
Certificate of Death	Reg. No.

3. Tima of Death

13:45

9. Birthplaca (Stata or Foraign

211

21050 Approximata Interval Between Onset and Death

24b. Wara autopsy findings available prior to complation of ceusa of death?

December 31, 2000

10d. Insida City Limits

1 ☐ Yas 2 No

Yea

2000

Harford

SHARON A. OMEARA 1. Decedeni's Nama (First, Middla, Last) 2. Data of Death Month Day **Physician** December 30, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner 1335 Old Post Road Havre de Grace If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 XF 214-54-4294 Yrs Director Usual Residence of Dacedant death with the Maryland 10a. Slata 10b. County 10c. City, Town or Location 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Hasilit and Mental Hygiens.

Department of Hasilit and Mental Hygiens.

The marked other than "natural", or itema 23a or any Injury or other traumatic event, to a section or ment be a 21078 Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, apecify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc., 12. Was Dacedant Evar in U,S. Armed Forcas? 11. Marital Status 1 ☐ Yas 2 X No It Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1□ Yas 2 No Baltimore, Maryland 21215-0036 Specify: Specify: ( ) by 3 Nowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa, DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) Ke 10 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Father's Nama (First, Middla, Last) Be 19a, Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) )11Q 20c. Location - City or Town, Stata 20a. Mathod of Disposition

1 □ Burial 2 M Cramation 3 □ Ramoval from State

4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Nama of comatary, cramatory or other place) Jan 3 22. Nama and Addrass of Facility EVONS 21. Signatura of Funaral Sarvice Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Cardiovascular Disease /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Dua to (or as a consequance of) Physician/Medical Examiner the attending physician and hed for use as the bunal-transit The law requires that the death cartificate be axecuted Sequentially list conditions, if any, laading to immediata cause. Enter Undarlying Cause (Disease or injury that initiated avants Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Dua to (or as a consequanca of) rasulting in daath) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed by the 1 Yes 2 No 3 Probably 4 Unknown by 24a. Was an autopsy performed? paga 2 should Completed peen this cartificate has 18 Yas 2 No Be 25. Was cese reterred to medical 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 2 TX Yas 2 No 27. Manner of Death 28b. Tima of Certification:

or Attending Physician: Director: After this cartific I in by the funeral director, after death. filled in by To the Hospital of within 24 hours at To the Funeral D completally filled

1/2 Yes 2□ No Othar: 4 Nursing Homa 5 Rasidance 6 Mothar (Specify) SCENE 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural Injury

5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29d. Data signad (Month, Day, Year) 29b. Signalura and titla of certifiar 29c. Licansa number

OCME 30. Nama and addrass of person who completed ceuse of daath (ftam 23a) (Type, Print)

hute Dennis 111 Penn Street, Baltimore, Maryland 21201

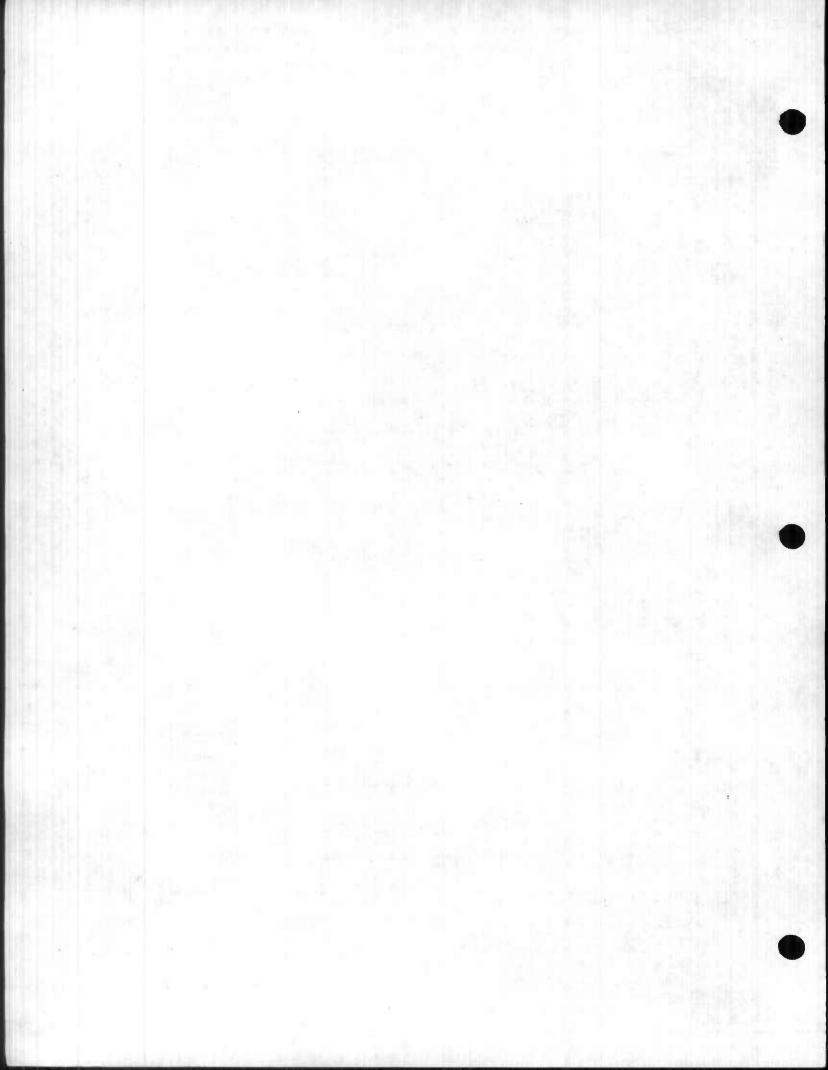
31. Data filed (Month, Day, Year) State Registrar

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JAN 0 5

32. Registrar's Signatura



after To the Hospital or within 24 hours af To the Funeral Di completely filled in

> State Registrar

edical

29a. Certifier

31. Dete filed (Month, Day, Year) JAN 0 5 2001

Ma

29b. Signature and title of certifier

no DCKE

and address of person who completed cause of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Şigneture

DOCKS!

**DHMH 16 Rev 6/95** 

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.

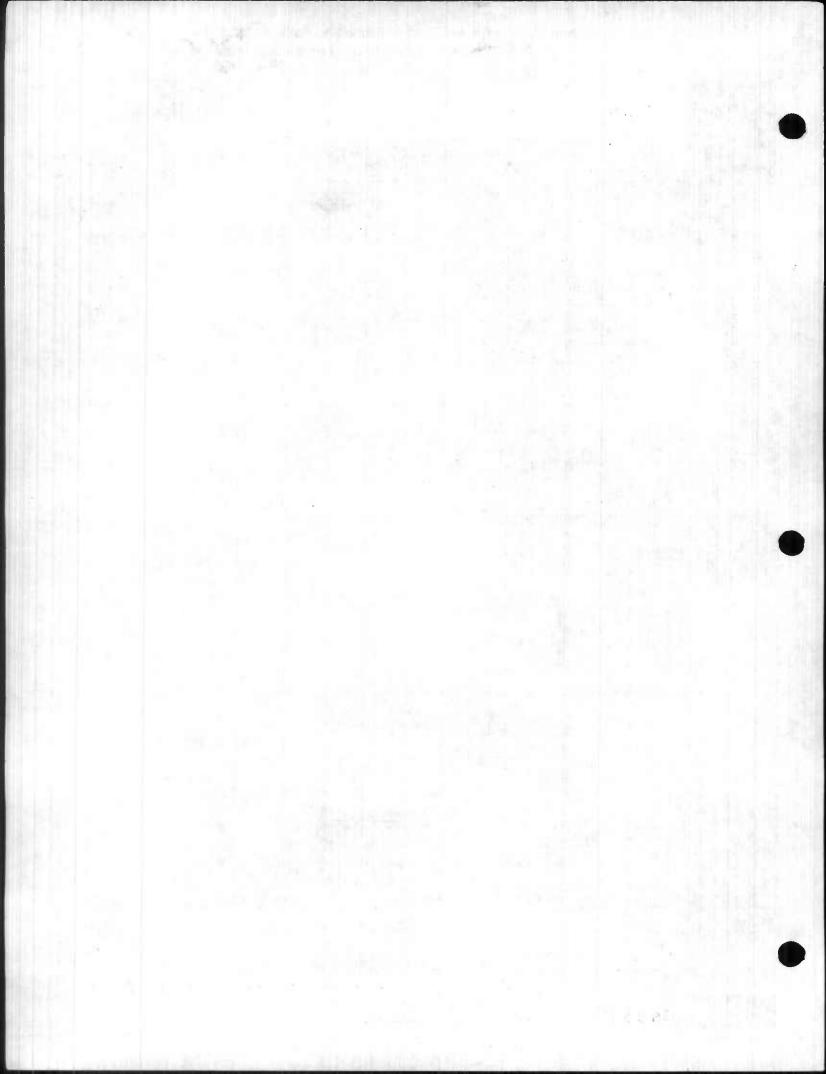
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end manner stated.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DECEMBER 17, 2000



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene McKinley Roberts UNPENDED 072301: ITEMS# 1,23a,b,ptII,27 per ME G797 SS Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Year Month Physician December 20, 2000 11:27 P.M. DAVID McKINLEY ROBERTS /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Johns Hopkins Bayview Medical Center Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthpiace (State or Foreign Country) 6. Şex **Funeral** M 20 F Director 244-80-7314 DEC. 17, 1950 NORTH CAROLI Usuai Residence of Decedent with the Maryland 10d. Inaide City Limits 10c. City. Town or Location 10a State 10h County I be filed within 72 hours after death with the Marylar ntal Hyglene. or other than actural; or items 23a or 28a-f show avant, ma together man the nouting a Yes 2□ No Director MD. N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A.

14. Race - American Indian, 3834 10th STREET Funeral 21225 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□ Yes 2 No Specify: 3 Widowed 4 □ Divorced by BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER 12th TRUCKING permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked othe any Injury or other treumstic avant price. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Lest) 89 EDWARD ROBERTS MARY BULLOCK 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ST. BALTIMORF MD. 21225 . 1/2/20pt 20c. Location - City or Town, State 3834 GWENDOLYN Y BROWN-FRIEND 10th 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 1/2/2001 20a. Method of Disposition Burial 2 Cremation 3 Removel from State OWINGSMILLS.MD. GARRÍSON FOREST VET CEM. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licanspe LEWIS T.GWYNN FUNERAL HOME LEWIS T. GWYNN eures 4517 PARK HEIGHTS AVE BALTO.MD.21215-639 her 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause or each line. Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a. CARDIAC ARRHYTHMIA Examiner Due to (or as a consequence of): Physician/Medical Examiner ATHEROSCLEROTIC CARDIOVASCULAR DISEASE strending physicien and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as a consequenca of) Due to (or es e consequenca ol): signed by the signed of the detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ₩ Unknown DIABETES MELLITUS Division of Vital Records, by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy Completed performed? page 2 s 1 ¥es 2 □ No 1 Yes 2□ No Physician: director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? 1 AYes 2 No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this After this 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: Attanding 5 Pending 1 K Neturel s after death.

I Diractor: After din by the fundament 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ To the Hospital o within 24 hours af To the Funeral D completely filled I 29a. Cartifier edical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and pleca, and due to the ceuse(s) end menner es steted. 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 29c. License number O.C.M.E. December 22, 2000 20 wite 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) hutemo 111 Penn Street, Baltimore, Maryland 21201

State Registrar JAN 0 5 2001

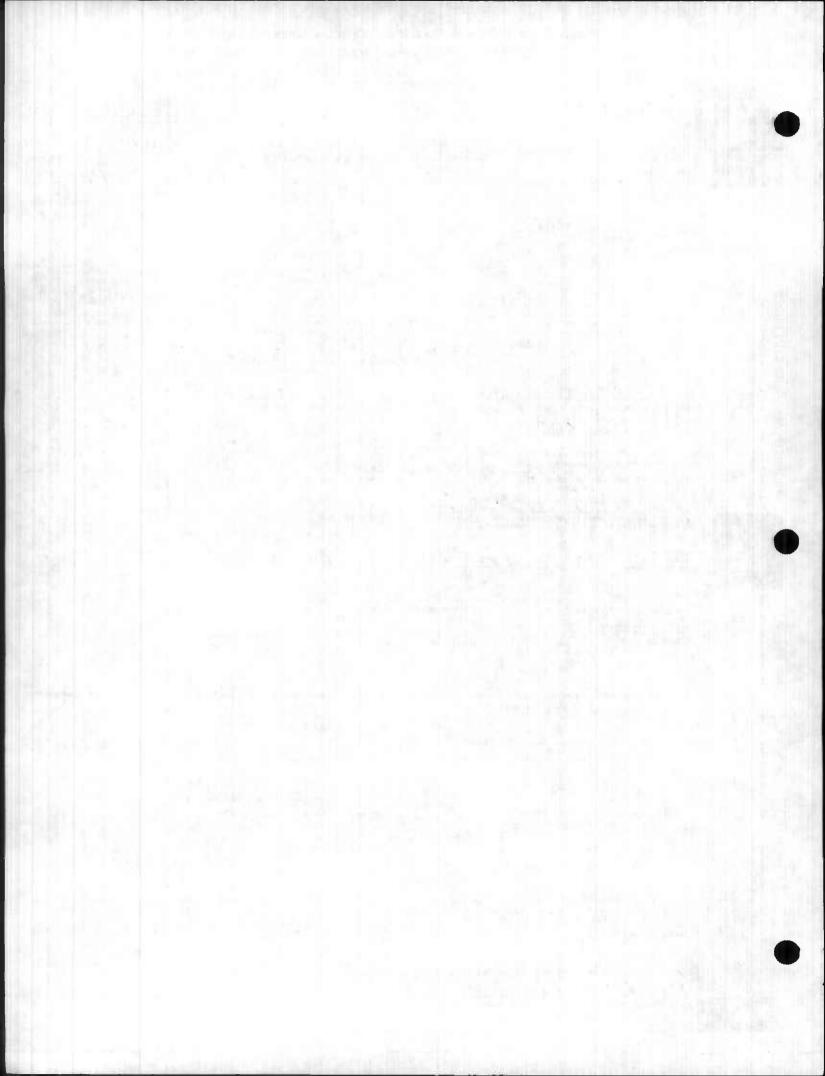
32. Registrer's Signature

Sparker !

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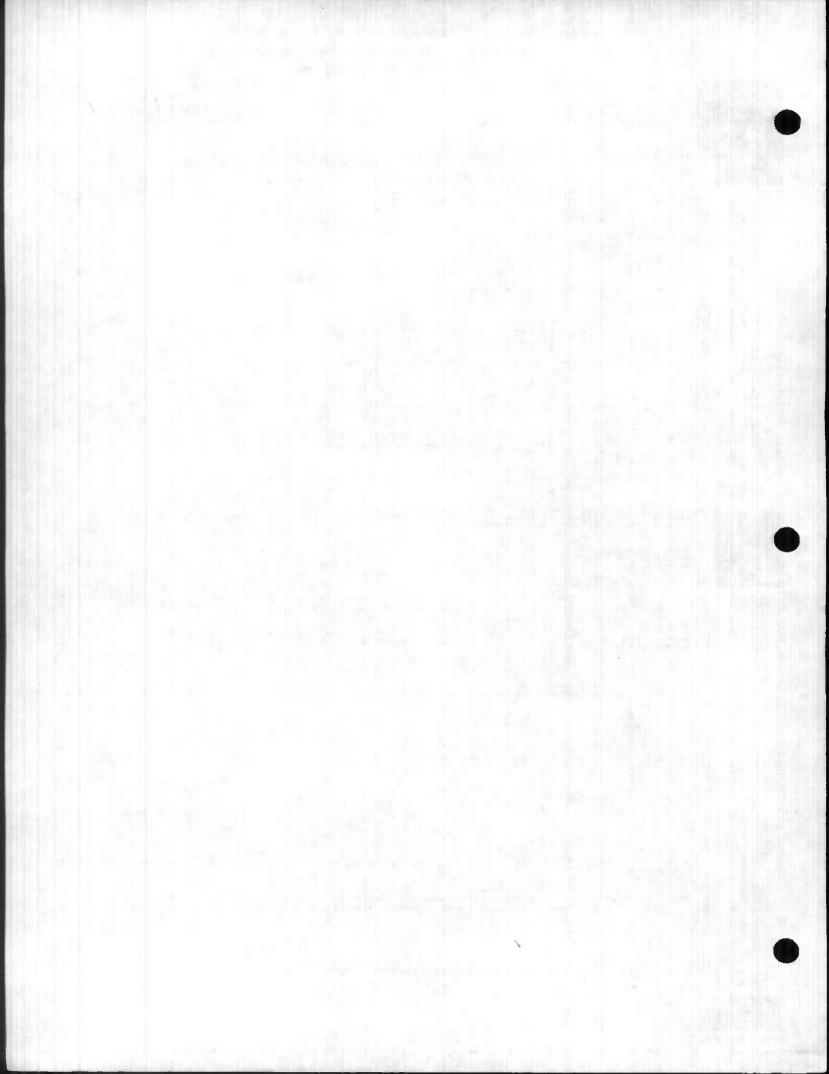
Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $\cup$   $\cup$ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** apence 2 /Medical 4b. City, Town, or Locetion of Death 4a Facility Name (If not institution, give street end number) County of Death Examiner HMORE ord 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Days 1 M 2 F Yrs. 212-20-007U Usuel Residence of Decedent Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director PNEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? LSA . Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Detes: 12 . Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Merital Status 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specity: While Specify. by 3 ☐ Widowed 4 ☐ Divorced To Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) nt of Health other 20a. Method of Disposition
1 ☐ Burial 2 DiCremation 3 ☐ Re 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dogate 31 noval from State Department of Important: If eny fajury or page. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee Evans 23a-Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 21234 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) MELANOMA METASTATIC Examiner Due to (or as a consequenca of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burlal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequenca of) P.O. Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown 1 Yee Division of Vital Records, by 24b. Were autopsy findings eveilable prior to completion of cause of death? pptal or Attending Physician: The law require ours after death.

eral Director: After this certificate has been signed in by the tuneral director, page 2 should filled in by the tuneral director, page 2 should 24a. Wes en autopsy performed? Completed 2 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartille 29c. License number 30, mame and address of person who polylpleted cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 5 2001 Registrar oaks



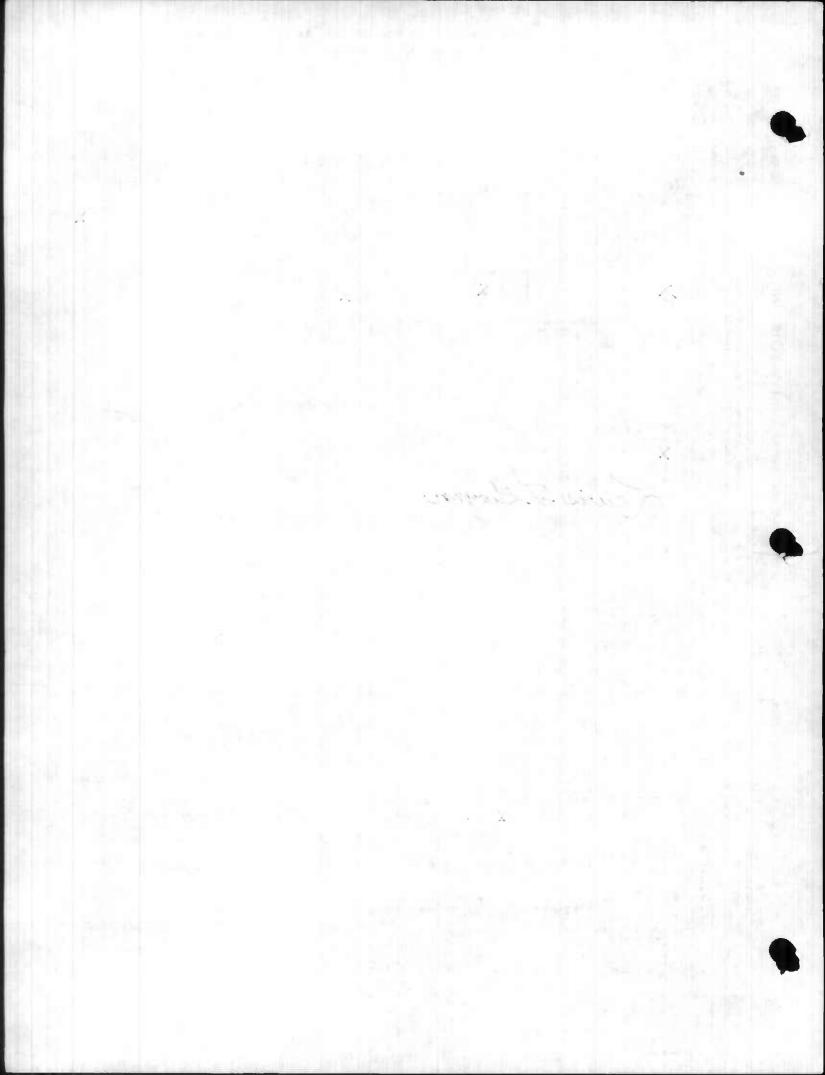
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0042591

	Seattle Interest			Cer	tificat	e of l	Death			Reg. No.			
o Dhuaisia	1. Decedent's Name (First, Middle	le, Last)		77					2. Date of De Month	ath Day	Year	3. Time of Death	
° Physician /Medical	HARRY WARREN	STEVENSON							DECEM	DER	7,2000	19411	
Examiner	4a Facility Name (If not institution	n, give street and nu				4	b. City, To	wn, or Lo	ocation of Deat	h 4c. Cour	ity of Death		
	Stella Maris	*			10.15			timo					
Funeral Director	5. Social Security Number 150-24-1467	6. Sex 1⊠ M 2□ F	7. Age (In yrs. last I	birthday) Yrs.	If Under Months	1 Yaar Days	If Under Hours	24 Mrs. Min,	8. Date of Bir (Month, De Oct /,	1931	9. Birthp Coun Penn	lace (State or Fore lace) Sylvania	
,	Usual Residence of Decedent		100 City To	um or Lo	antion						4	Od Josida City Lim	
of short sho	MD 10b. County Princ	e Georges	10c. City, To		Laure	1						0d. Inside City Lim 1 ☐ Yes 2X	
r tems 23a or 28a-f s thet must be notified Funeral Director	10e. Street and Number 9170 Stebbing	Way #L			10f. Zip	Code		2072	23		of What Country? USA		
natural, or items 23a or 28a-f show stell Examiner must be notified at steel by Funeral Director	11. Marital Status  1 Never Married 2 Man  3 Widowed 4 Divorced	ried 1 Yes If Yes, G	2 No	11	Vas Deced Yes, spec	ify Cuba	ispanic Ori in, Mexicar Specify:	gin? (Sp i, Puarto	ecify Yas or No Rican, etc.)	В	14. Race - American Indian, Black, White, etc. Specify: White		
natural", or		Year or I		Sa Deced	ent's Usua	I Occup	ation			16b. Kind of	Business/Inc	fustry	
- 2	(Specify only highe	st grade completed,	)	(Give I	kind of wo	k done d	during mos	t of work	ing	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,	
Hygiene. ont, tre Her	Elementary/Secondary (0-12)	College	(1-4or 5+)	pedi	ter				leathe	r fur	niture		
I DE A	17. Father's Name (First, Middle,	Last)	1			18. Moth	er's Nam	e (First, Middle					
5 5 m	Bertrum Steve	nson					El	izat	eth Fa	gan			
BEE	19a. Informant's Name/Relations	ship (Type, Print)	1	9b. Mallin	g Address	(Street			al Route Numb		vn, State, Zip	Code)	
12 p	Cathy Jolin/da	ughter		9170	Ste	bbin	g Way	#L	Laure	1, MD	20723		
A Par	20a. Method of Disposition  1  Burial 2  Cremation  4  Donation 5  Other (S		20b. Place ceme	of Dispos tery, crem	sition (Nar natory or o	ne of ther plac	ce)		Date	20c. Location	n - City or To	wn, State	
Department of Important: If he any injury or o	21 Signature of Euneral Service Ronald  23a Parti. Enter the disease, or heart failure. List	1/16	love	7 E	Balti	nore	-	212	201		timore	Approximata	
nding physician end immusers as the burial-transit and immusers and im	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. <u>// (//</u>	Due to (or as				ani	<del>y</del> m					
la lor	Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant condition	d	Dua to (or as			ausa Oiv	en in Part		23b. Did	tobacco use	contribute to	o the cause of de	
90	Cerebrova	sculo	es alor		end		on in t are			Yes 2 No			
s been s 2 should pleted										s an autopsy ormed?	av co	ara autopsy findin ailable prior to mpletion of cause death?	
page page									1 🗆	Yes 20H5	10	Yes 2□ No	
certificate rector, pag	25. Was case referred to medica examiner?							e of Dea	th (Check only	one)			
T di	1 Yes 2 No  27. Manner of Death 4 Natural 5 Pendin	28a. Date (Mo		Outpation  Time of Injury		8c. Injur Wor	y at k?		ome 5 ☐ Res 28d. Describe	how Injury occ		W HOSP	
octor: by the	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	1 ☐ Yes 2 ☐ No  Office 28f. Location (Street and Number or Rural Route Number, City or Town, State)											
Funer fely fill	29a. Certifier (Check only one)  29a. Certifier (Check one)  29a. Certifier (Check one)  29a. Certi										rred at the time, date and place, and due to the cause(s)		
within To the comple	29b. Signature and title of certifie	or			29	. Licans	a number			29d. Data sig	ned (Month,	Day, Year)	
	Ital hour	) WD				DA	10 8	35	4			18,20	
	30. Name and address of person	SEBER	9 30	/ <	Print) S+	PAU	Il F	/	BAI	4: MOR	RE P	D 212	
State Registrar	31. Date filed (Month, Day, Year)	5 2001	Registrar's Signature	1	4	100	nks						



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#5 perFHG791 1/10/01 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day **Physician** 13:05 **JEFFREY** SHIELDS December 28, 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1X M 2 F Months Yrs. Director 218-96-2394 OCT.23,1979 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Нете 23а 4819 WILERN 21215 U.S.A. 14. Race - American Indian. 12. Wes Decedent Ever in U,S.
Armed Forcas?
1 ☐ Yes 220 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. Never Married 2 Married natural, or 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry filed within Hygiene. ther then Elementary/Secondary (0-12) Collega (1-4or 5+) 12th UNEMPLOYED N/A 1 year Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be to end Mental F Is merked JEFFREY ALLEN SHIELDS DENISE MARIE MYERS 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2
Department of Health er
Important: If item 27 is DENISE M. MYERS-MOTHER WILERN AVE BALTIMORE MD. 21215
on (Name of Date 20c. Location - City or Town, State Baltimore, 20b. Ptace of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Buriat 2 Cremation 3 Removal from State
Donation 5 Other (Specify) ARBUTUS MEMORIAL PARK 1/3/00 ARBUTUS MD EVIS T. GWYNN 22. Name and Address of Facility 21. Signature of Fundral Service Licensee LEWIS T.GWYNN FUNERAL HOME Jevynon 23a. Pert1. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, approximate shock, or heart failura. List only one cause on each line. Interval Between Onset and Death **Physician** Immediate Cause (Finat disease or condition rasulting in daath) /Medical Examiner neumonia Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Diseasa or injury that initiated events resulting in death) Last Due to (or es e consequence of): Sepsis Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown alcohol Records, by 24b. Were autopsy findings eveilable prior to complation of cause of daeth? 24a. Wes en europsy performed? Completed 2 No 1 Yes 2 No 1 Yes Division of Vital Be 25. Was cese referred to medicet 26. Placa of Death (Check only one) Hospital: 1 Inpetiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yes 2 No 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred Affer t Natural 5 Panding investigation after death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A 4 Homicida To the Hospital o within 24 hours at To the Funeral Di to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as staled.

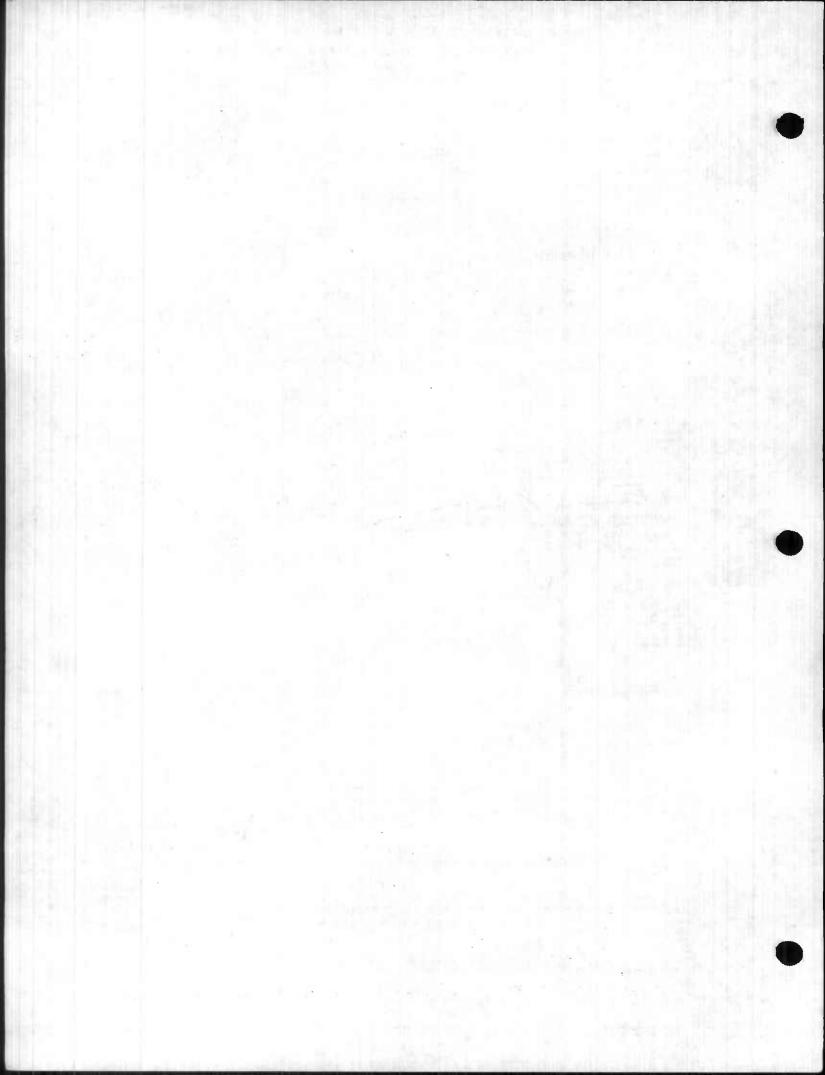
| Contituding Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Dale signed (Month, Day, Year) 29b. Signature end title of certifier Deeuber 28, 2000 30. Name and a dress of person who completed cause of death (ttem 23a) (Type, Print) Baltimore Sinai Hospital Crister 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State JAN 0 5 Registrar aarks



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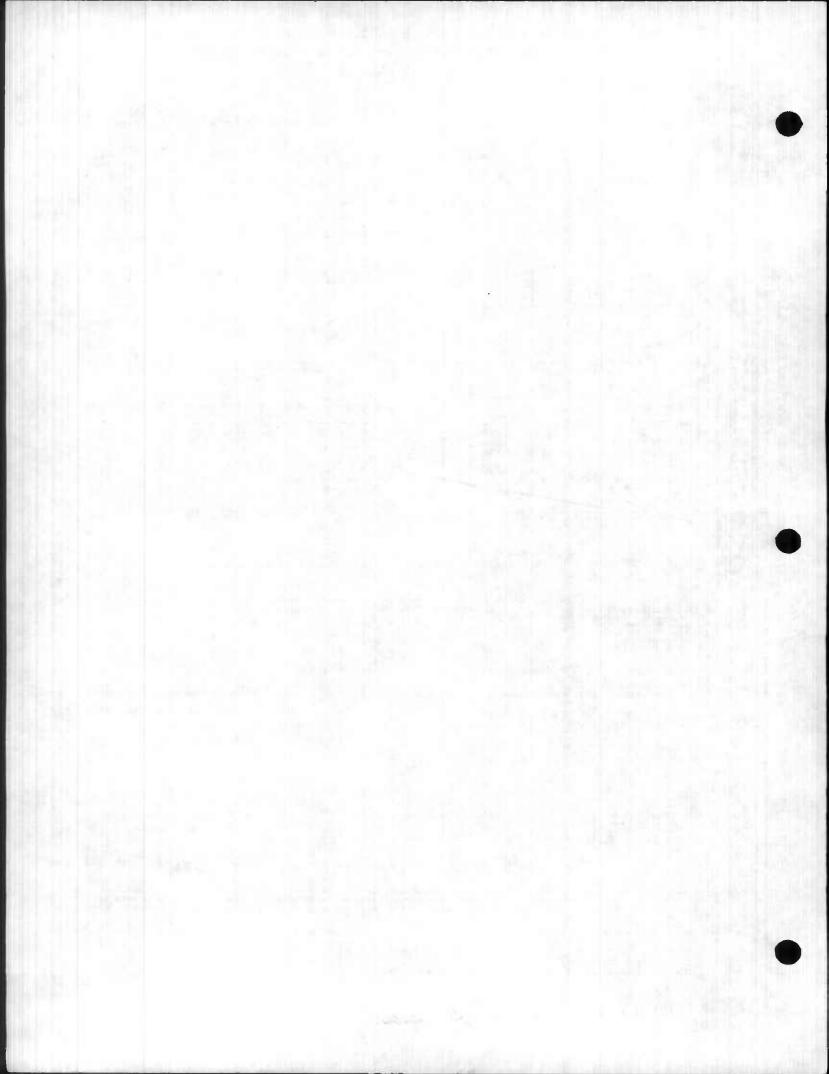
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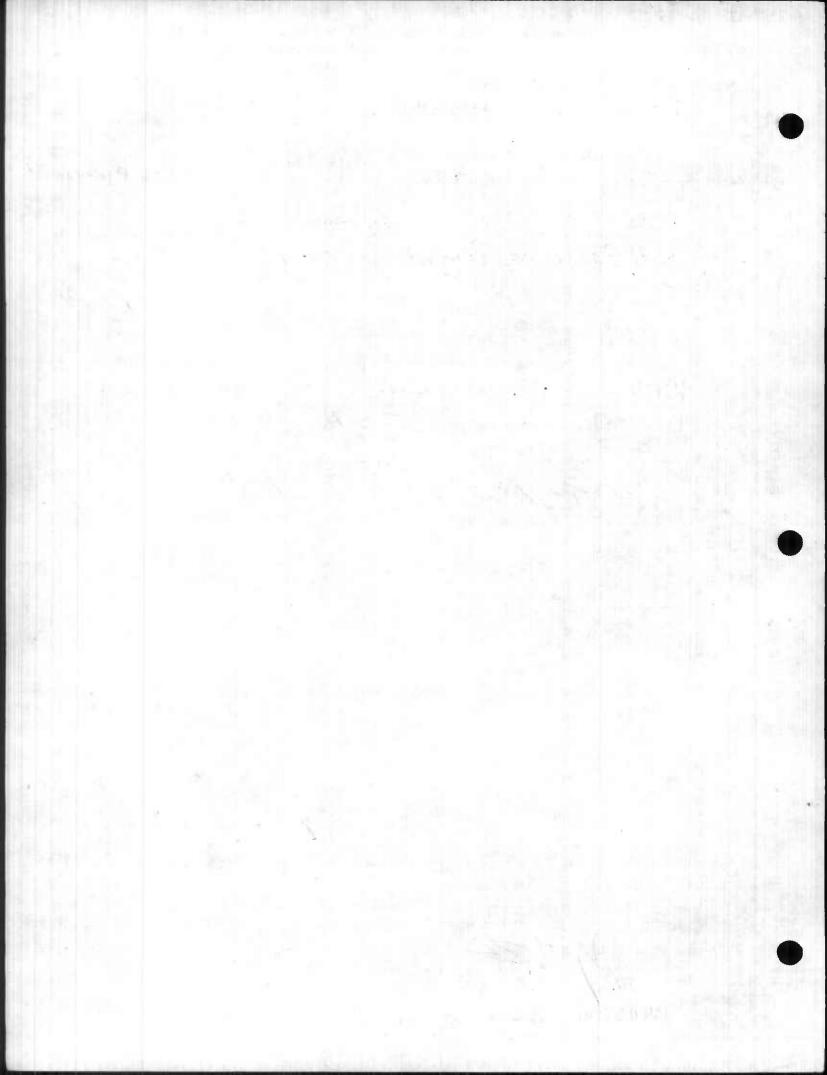
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### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

Seward Dennis I AMEND# 23.27	State of Maryland / Department of Health and M &28a-f per ME G793 030901 SS Certificate of Death		ene	42598
	1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
Physician	Dennis Dale Seward	Month ecember		Year 000 04:55 A.M.
/Medical Examiner	4a Fscility Neme (If not institution, give street end number)  4b. City, Town, or Lo		4c. County o	
Examiner	2121 Sparrows Point Road Edgemere			imore
Funeral	5. Social Security Number 1 / 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, )		9. Birthplace (State or Foreign Country)
Director	10-M 20 F 44 Yrs. Months Days Hours Min.	(Month, Day, )		mary land
	Usuel Residence of Decedent	5 01		7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7
how	10a. State 10b. County 10c. City, Town or Location			10d. fnside City Limits
the Marylar 28e-f show notified at	MD Baltimore			1 ☐ Yes 2 ☐ Ño
frar death with the Manyland frame 23s or 28s-f show frame must be notified at Funeral Director	10e. Street and Number	100	g. Citizen of Wi	hat Country?
23. E	2121 Sparrows Point Rd. 21219		45	A
items international	11. Maritel Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexicen, Puerlo	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc.
P. P. P. F.	1 Never Married 2 Merried 1 Yes 2 No Specify	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify:	01
:1215-0036 within 72 hours aftaren and natural; or its than natural; or its than natural or its manifest Earnin ompleted by Fu	3 □ Widowed 4 □ Divorced Yeer or Dates:		Opochy.	Black
5-(5-)	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work	inglock. 16	6b. Kind ot Bus	iness/Industry UNK.
vithin within than than the we	Elementary/Secondary (0-18/40/C College (1-4or 5+)			
d 21215-0 filed within 72 ho thysiena. why than natur ant, first Medical		/P*** - A A A A A A A A A A A A A A A A A		1
Be doth	17. Father's Name (First, Middle, Last)  18. Mother's Name  19. Add 19	(First, Middle, Mi		1
faryland 212' 2 should be filed within and Mental hygiena. In marked other than naumatic avent, for the To Be Comp	William McCalvin Seward Margo	et Di	Sewa	
Maryland 21215-0036 nd 2 should be filed within 72 hours aft lift and Mental Hygiena. 27 le marked other than "natural", or retaumatic avent, in Medical Earn To Be Completed by F	19a. Informant's Neme/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Fluri	al Route Nurliber,	City or Town, S	State, Zip Code)
	20a. Method at Disposition 20b. Place of Disposition (Name of	Duty 2	On Landing C	W. IVD
O SPILL	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	Oc. Location - C	City or Town, State
Baltimore, pemit. Pagas 1at Department of Has Important: If item is any injury or othe page.	4 Donation 5 DODAY (Space) 1 UShell Cemetery 1	14/01/	20/41	nore, marylan
Balti Departm Mports any Inju	21. Signature of Funeral Service Microsee 22. Name and Address of Facility	7134499	Ma. 11	1639 10. 1980an
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	23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as circular shock, or heartfallure. List only one cause on each line.	or respiratory arres	st,	Approximate Intervel Between
Physician				Onset and Death
/Medical Examiner	Immediate Cause (Finel disease or condition NARCOTIC AND COCAINE INIOXICATION			
	resulting in death)  Due to (or as a consequence of):			
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D a 8 a O	that initiated events resulting in death) Last  Due to (or es e consequenca of):			
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Vision of Vital Records, P.O. Box 68 Attanding Physician: The law requires that the death certifica rcoath.  crost skath.  by the funeral director, page 2 should be detached for use as the filecation: To Be Completed by Physician/Med	Pert il. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.	23b. Did tob	acco use cont	tribute to the cause of death?
P.O. hat the de by the detached		1 Yes	2 2 No	3 Probably 4 Unknow
Division of Vital Records, F for Attanding Physician: The law requires the plant decords. After this certificate has been signed in by the funeral director, page 2 should be deertification: To Be Completed by F		0.43 1110		24b. Were autopsy tindings
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Rec e law has b		1		completion of ceuse of death?
The law requir		1 XYes	s 2 No	Yes 2□ No
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of V Physic this of this of this of	1 ☑ Yes 2 ☐ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	me 5 Residen	nce 6X00the	(Specify) Scene
On C	27. Manner of Death  1 Naturel 5 Pending (Month, Day Year)  1 Notice investigation inv	28d. Describe how	w injury occurre	d
Division ( Ital or Attanding P Ital or Attanding P Ital and Italian Italian Italian Italian Italian Certification:	2 Accident 12-30-00 4:40	subject in	gested di	rugs
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he Hospit in 24 hour he Funer pletaly filli edical	29a. Certifier  (Check only  Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred.)	end due to the cau red at the time, dat	use(s) and man te and place, a	nner as stated. nd due to the cause(s)
the fathin 2 of the fathin 2 of the fathing Med	and manner stated.			
OT VIEW	29b. Signature and title of certifier 29c. License number	29	d. Date signed	(Month, Day, Year)
	O.C.M.E.		Decemb	er 30, 2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
	JACK M. TITUS, M.I) 111 Penn Street, Baltimo	re, Mary	land 21	201
State	31. Dete filed (Month, Day, Year)  32. Registrar's Signeture			
Registrar	JAN 0 5 2001 Bener & Sparks			



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time ol Death Month MILTON 2000 STEVENS Facility Name (If not institution, give street and number 4b. City, Town, or Location of Deeth 4c. County of Deeth LevinDALE HeBREW& GERIATRIC CENTER+ HOSPITAL NIA If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 10 M 2□ F Months Deys 219-62-365 Usual Residence of Decedent AUG. 26, 1947 MD 10b. County 10c. City, Town or Location 10d. Inside City Limits 4- Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2 IVER! 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 22 No If Yes, Give Year or Detes: 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FOOD + Li Quin BANTENDOR NONE 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) STEVENS MARSHA 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silven Spring: Mal, 21902 STEVENS 2110 prother 20b. Place of Disposition (Name of gemetery, crematory of other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) STERN SMETERY e 22. Name and Address of Facility DELLA NOCE + FUNERAL HOME Sons Tant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Br40, Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death)

**Physician** /Medical **Examiner** 

After this certificate has been signed by

after death.

Director: After this certifice
J in by the funeral director, g

filled in by

i or Attending P Division

To the Hospital of within 24 hours a To the Funeral D

Physician/Medical Examiner

by

Completed

Medical Certification: To Be

**Physician** 

/Medical

Examiner

10a. Stete

MD

eo

**Funeral** 

Director

23a or 28a-f ahow

Director

Funeral

g

Completed

traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1. Department of Health and Mental Hygiene.
Importunit: If Item 27 is marked other than "naturel", or Name 28a and Injury or other traumatic event, the sen

Maryland 21215-0020

P.O.

of Vital Records,

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting In death) Last

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of death?

1 Yes 2 No 26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Mannel of Death

1 Natural

29a Certifier

2 Accident

Hospital: 5 Pending investigation

28a. Date of tnjury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 Yes 2 No

Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28l. Location (Street end Number or Rural Route Number, City or Town, State)

6 ☐ Could not be 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Cartifying Physictan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signeture end title of certilier

29c. License number

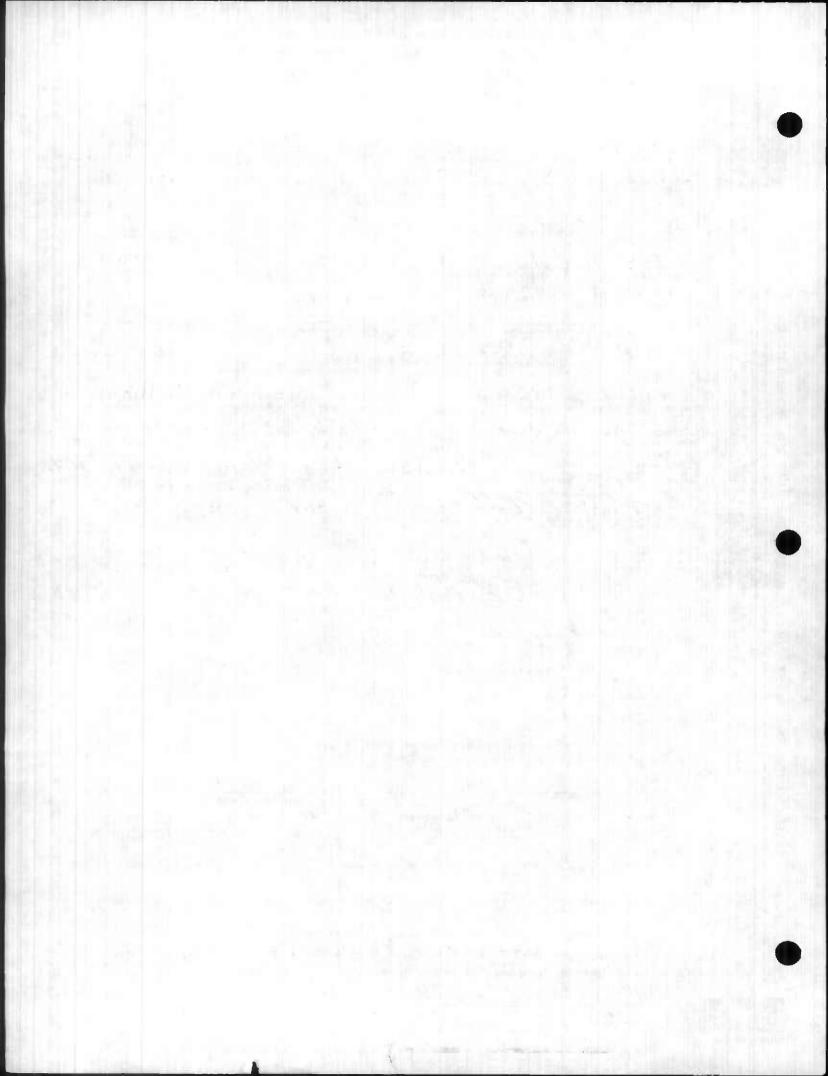
29d. Date signed (Month, Day, Year) 0-2000.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Dete filed (Month, Dey, Year) JAN 0 5

32. Registrer's Signeture

State Registra



00-7439-510 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene **GEORGE** Certificate of Death TALIFERRO 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Deeth Day Month **Physician** GEORGE TALIFERRO DECEMBER 25, 2000 23:25 PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 3921 FLOWERTON ROAD 9. Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. last birthdey) If Undar 1 Yaar | If Undar 24 Hrs Funeral Days Months Hours M 2 F 725-03-012 Yrs. Director Usual Rasidence of Decedant 10a. Stata 10c. City, Town or Location 10b. County 10d, fnsida City Limits SALTIMORE Yes 2□No Directo herre 23a or 28a-f iner must be notifie 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country2 FLOWERTOW N Funeral 12. Was Decedant Evar in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, 7 is marked other than "natural", or item traumatic event, the Medical Examiner. Black, Whita, atc. 1 ☐ Never Merried 2 ☐ Married 1□ Yas a No Baltimore, Maryland 21215-0036 Specify: by 3 Widowad 4 □ Divorced ACK Yaar or Datas: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grada completed) Collega (1-4or 5+) Elemantary/Secondary (0-12) echanic AUTO MainTenance 18. Mother's Name (First, Middla, Meidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Pages 1 and 2 should be nent of Health and Mental INKNOWN Corge 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) Department of Health at Important: If Ilem 27 is any injury or other trau pfice. 1315 BAW. MO USeph ALIFERRU INCOIN WOODS 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other pleca) Data 20c. Location - City or Town, Stata 1 ☐ Buriel 2 Cremetion 3 ☐ Removal from Sfete DaLTO 01-02-01 4 Donation 5 Other (Specify) eTro GEMATURY 21. Signeture of/Funaral Service Licensee 22, Name and Address of Facili Home towell 23a. Pent1. Enter the disaesa, or complications that caused tha death. Do not antar tha mode of dying, such as derdiac or habitetory errest, shock, or heart failure. List only one cause on each line. 21205 MO DOLTO Approximata Interval Batween Onset and Death Physician /Medical Immediata Causa (Final disaasa or condition rasulting in death) ATHEROSCLERUTIC CARDIO VASCUM Examiner Dua to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceusa. Entar Underlying Cause (Disaasa or Injury that initieted events rasulting In death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequance of): attending f Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Usknown MCOMOLISM þ 24b. Ware eutopsy findings eveilable prior to complation of ceuse of daath? 24e. Wes en eutopsy Completed PANTIAL After this certificate has I funeral director, page 2 s 1 Yes 2 □ No Yes 2 No Hospital or Attending Physician: Be 25. Was cesa rafarred to medicel 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) SCENE P 15 Yas 2□ No 27. Mennar of Death 1 Natural 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury Certification: 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Pending investigation 1 Yas 2 No ector: A by the fi 2 Accidant 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) To the Hospital or Att within 24 hours after of To the Funeral Direct completely littled in by 4 T Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Cartifiar Medicai (Check only one) 29b. Signature and Jittl) of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) OCME DECEMBER 26, 2000 Person who complated causa of daath (Item 23a) (Type, Print)

G. A. PRUR, M. P. 111 Penn Street, Baltimore, Maryland 21201 30. Name and edde

State

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day,

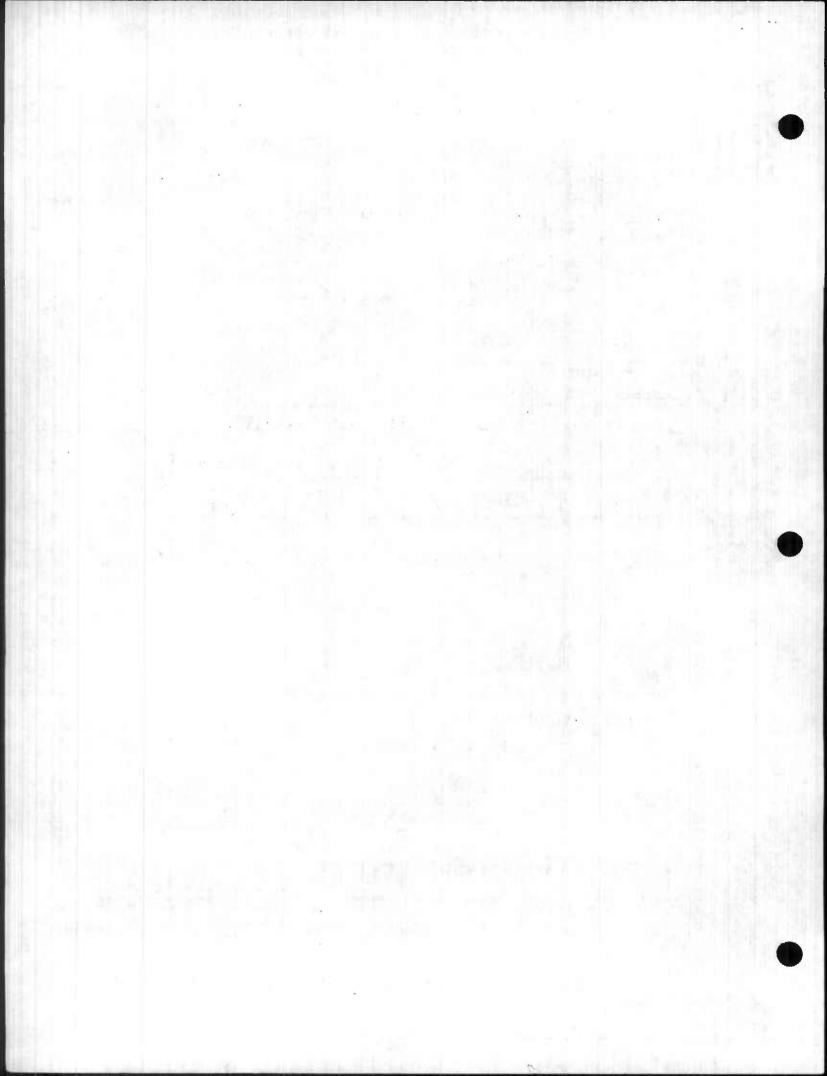
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2007

JAN 05

32. Registrar's Signefura zenera

makes



a ( bot Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED TTFM #20h.c.,21&22 per fh G791 011101 SS 1. Decedent's Nama (First, Middla, Last) 2. Data of Death December 26 **Physician** JEREMIAH GRAFTON TALBOTT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) **Examiner** Baltimore Sinai Hospital of Baltimore lere Mirach 6. Sex 1 M 2 ☐ F If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Days Hours Yrs Mar 22, 1947 149-44-7669 53 Director Usual Residence of Decedant 10a. Stata 10c. City, Town or Location 10b. County or 28a-f show the Medical Examiner must be notified at MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 5744 Jonquil Avenue "natural", or items 23a 21215 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ∑ No If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify. þ 3 Widowed 4 Divorced atient known 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) repairman home improvements 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be should be nd Mental utment of Health and Menta stant: If hem 27 is marked Milton M. Talbott Thelma Hughes 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Constance Talbott/spouse 2851 Walbrook Avenue Baltimore, MD 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20c. Locetion - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata in state Woodlawn Cemetery 4 ☐ Donation 5 🖾 Other (Specify) 1-11-2001 Woodlawn, MD 21. Signature of Fune al Service License Charlotte Wilson per Danald S. Wade, Director State Anatomy Board 655 W. 21201 5240 Reisterstown Rd Balt, MD mana 23a. Part1. Entar the disaasa, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Cerebral Herniation **Examiner** Dua to (or as a consequence of): Examine Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Disease or injury that initiated evenIs resulting in death) Last Dua to (or as a consequence of) Box 68760

g physician and as the burial-trans the attending physician Physician/Medical detached signed by d by has

Completed Be Certification: il or Attending P. after death.

Division of Vital Records, P.O.

Dua to (or as a consequence of):

Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to complation of ceusa of death?

Approximata Intarval Between Onsat and Death

4 days

42601

9. Birthplaca (Stata or Foraign

black

Maryland

2000

USA

3. Tima of Death

1:03 pm

10d. Inside City Limits

1X Yas 2 No

2□ No

28d. Dascribe how injury occurred

26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify)

1 ☐ Yas 2 No

25. Was casa rafarrad to medicel 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA

5 Pending

invastigation 6 Could not be 28b. Tima of

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specity)

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar

27. Mannar of Death

1 Natural

2 Accidant

3 Suicida

4 Homicide

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
20 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29d. Data signed (Month, Day, Year) 29c. Licansa number

29b. Signatura and titla of certifiar Mhurston MD

D 28855

January 2, 2001

30. Nama and addrass of person who completed cause of daath (Itam 23a) (Typa, Print)

HOSPITAL OF BLEBNOKE Rhonen Fishel MD, SINAI

State Registra

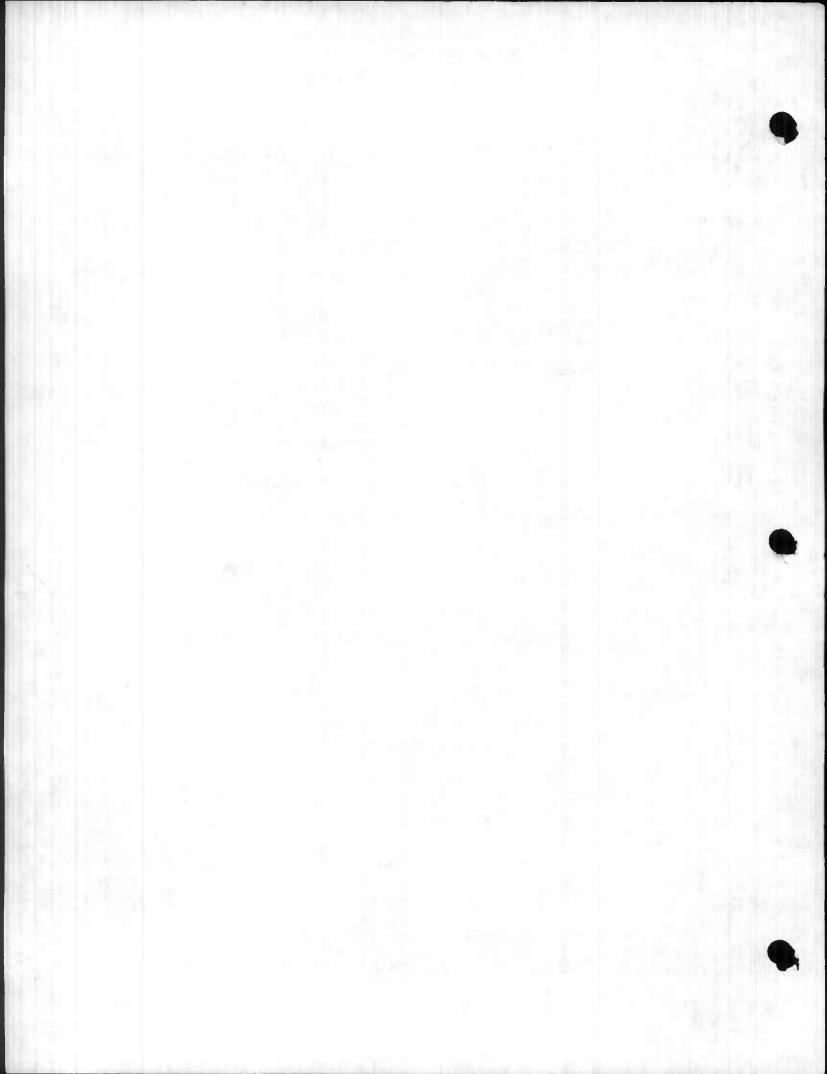
Medical

31. Data filed (Month, Day, Year)

32. Registrar's Signatura

**DHMH 16 Rev 6/95** 

To the Hospital within 24 hours a To the Funeral C completely filled



Please Type or Print in Biack Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Items#19a-b perABG791 1/16/2001 EW Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** LEON THOMAS december 27, 2000 2:09 AM /Medical 4a Facility Nama (ff not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL PRINCE GEORGES 8. Data of Birth (Month, Day, Mar 10, If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Months Min. Hours 38 577-29-7481 Director Usual Rasidence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits must be notified at Prince Georges Clinton 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 9211 Stuart Lane 20735 USA Herra 23a 12. Was Decedant Evar in U,S. Armed Forcas?

1 ☐ Yas 2 ☐ No Un If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 Navar Married 2 Married unk "natural", or 1 ☐ Yas 2 No Specify: Specify: black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation
(Giva kind of work dona during most of working
lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Hygiens unk unk 17. Fathar's Nama (First, Middla, Last) unk unk 18. Mothar's Nama (First, Middla, Maidan Sumama) Be h and Mental I 2 Pages 1 and 2 should? 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Department of Health a Important: If Item 27 is any injury or other tra Southern Maryland Hospital 7503 Surratts Rd Clinton, Md 20a. Mathod of Disposition 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) in State in state 21 Signature of Funeral Service Licenters Renald S. Wade, Director 22 Name and Addrass of Facility State Anatomy Board 655 W. Baltimore Street Marce 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and, or heart tailure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting In death) /Medical Examiner Dua to (or as a consequanca ot): Examine certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or injury that initiated events rasulting in death) Last attending physician end for use es the burial-trar Dua to (or as a consequence ot): Physician/Medical Dua to (or as a consaquance of): Part II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of geath? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Wara autopsy tindings available prior to complation of causa of daath? should i Completed 24a. Was an autopsy performad? cate hes i 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate Physician: Be 25. Was calsa ratarred to medical director 26. Placa of Daath (Chack only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) To 1 Yas 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA After this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima ot 28d. Dascribe how injury occurred Certification: Attending 1 Natural 5 Panding Invastigation death. 1 Yas 2 No To the Hospital or Attendition within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accidant 6 ☐ Could not be 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Sulcida 28a. Place of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 4 Homicida Contrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifian Medical (Check only one) and mannar stated. 29b. Signatura and title of contilion 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and address SCOH causa of daath (Item 23a) (Type, Print) Clinton, Md Rd 50 31. Data tiled (Month, Day, Year) 32. Registrar's Signatura State oorks

**DHMH 16 Rev 6/95** 

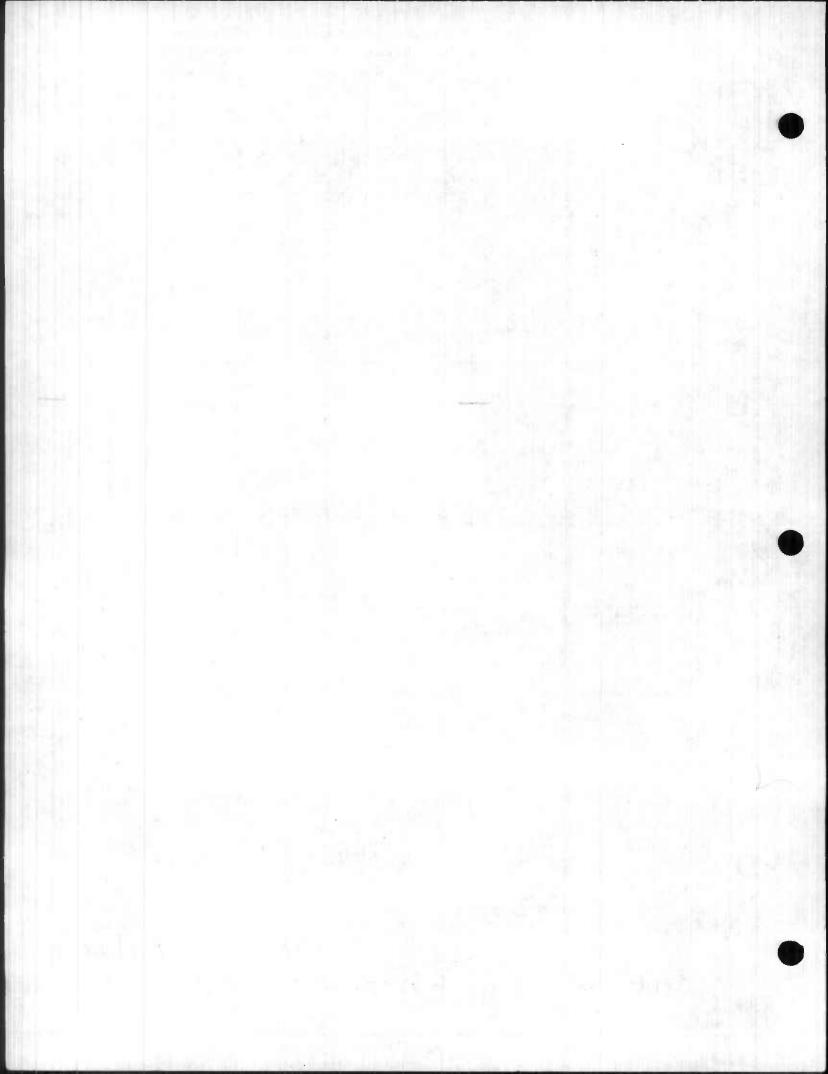
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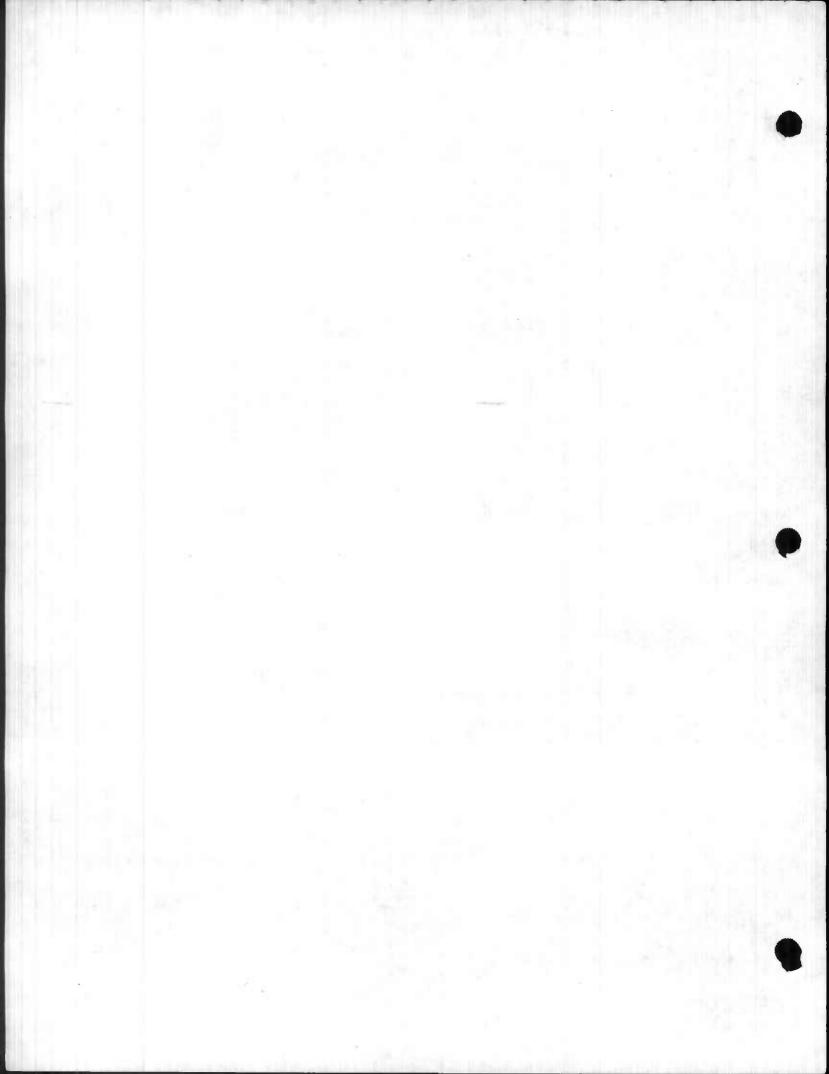
Thomas, Levi

**ORIGINAL** 



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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	10e. Street and Nu	Imbor		Das		p Coda		10a Citiz	en of What Co	
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			Wade, Direc	tor	22. Name ar State	nd Address of Facilit Anatomy	Board 6	55 W. B	altimo	re Street
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00-7563-510 Piease Type or Print in Biack indelible ink. Assure All Copies Are Legible. ihm State of Maryland / Department of Health and Mental Hygiene U STEVEN Certificate of Death WILLIAMS 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yaar **Physician** Williams, Sr. Steven Α. DECEMBER 31, 2000 23:06 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA BON SECOUR HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Min Months Hours 10 M 20 F Days 52 PA 218-44-0099 Director 01 - 29 - 48Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow ral", or items 23a or 26a-f ehov Examiner must be notified at MYes 2□ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 3452 Reisterstown Road USA Funeral 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2000 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian Black, White, etc. Never Merried 2□ Married "natural", or 1 ☐ Yes 2 ☐ No Specify. Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) se filed within 7. al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Roofer Roofing Company 11th Grade 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 is marked of eny Injury or other traumatic eve Evelyn Williams Washington Alexander 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 2101 College Avenue Apt.C-8 Phila, Sandra Williams 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XBuriel 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 01-05-2001 4 ☐ Donation 5 ☐ Other (Specify) Lansdowne, MD 21. Signature of Funeral Service Licenses 22. Name and Addrass of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset end Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) OF LIVEN CIRRHOSA Examiner Due to (or es e consequence of) Physician/Medical Examine death certificate be executed attending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Box 68760 Due to (or es e consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 1 Yes 2 No 3 Probably 4 Unknown signed by à 24b. Were autopsy findings eveilable prior to complation of causa of death? been sig 24a. Was en autopsy performed? Completed page 2 s PARADL 1 Yes 2 No certificate Division of Vital Physician: 25. Was case raferred to medical examiner? Be 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 1 Natural 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After To the Hospital or Attending 5 Pending investigation death. 1 Yes 2 No I Director: A id in by the fu 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) after 4 Homicide within 24 hours a To the Funeral I

State Registrar

edicai

29a. Certifier

29b. Signature and title of certifie

MULSMAN 31. Date filed (Month, Day, Year)

IANO



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

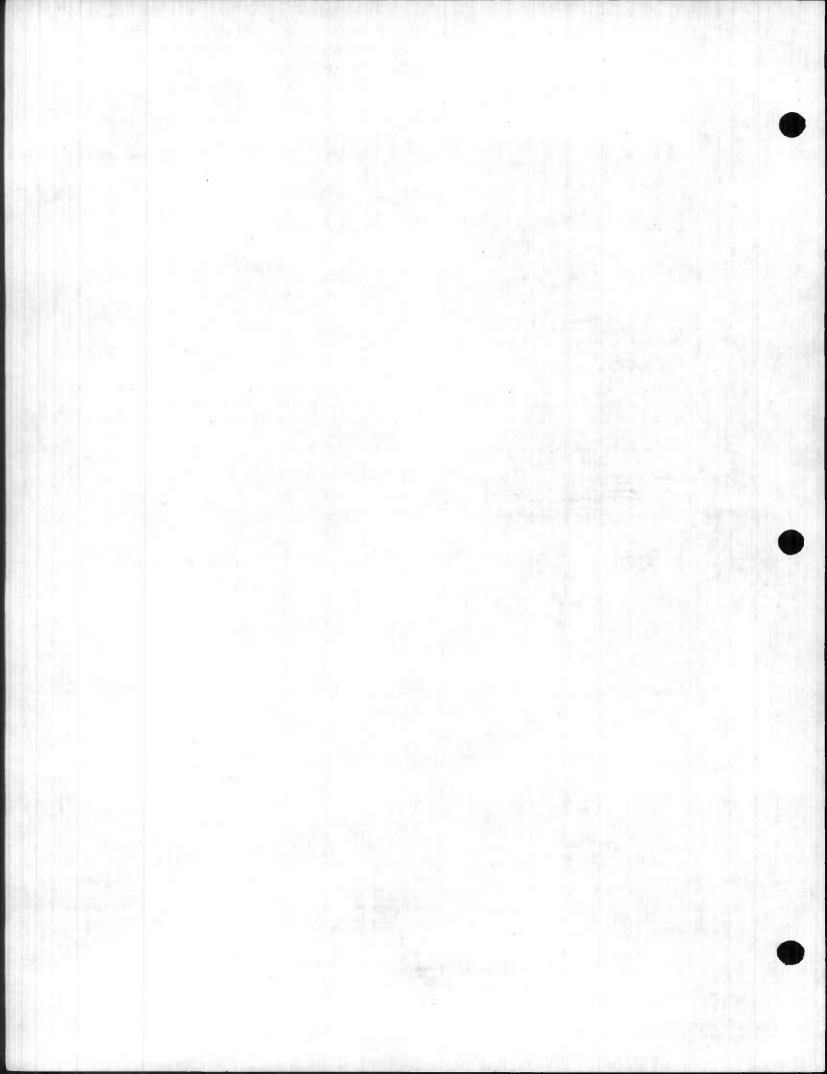
29c. License number

111 Penn Street, Baltimore, Maryland 21201

OCME

29d. Data signed (Month, Dey, Year)

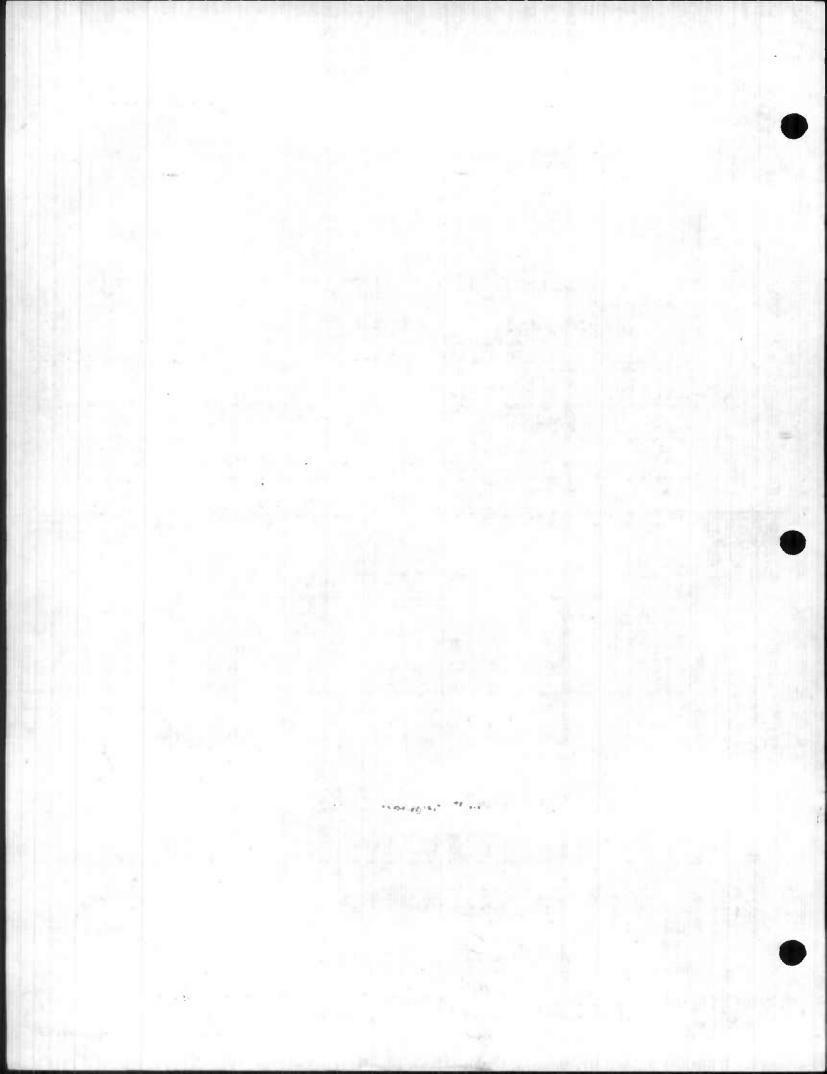
JANUARY 01, 2001



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	ı¥	Burial 2	Cremetion 3		State	emetery, crer	natory or other p					
			5 Other (Speci		V			Gardens	01-05	-01 Di	undalk	, MD
	23a. P	art1. Enter th	neral Service Lice Lice ne disease, or contralition only	b W 6	aused the deat	) w	M.C.Ma1 er the mode of d	ch FH 1.  ying, such as cardiac	101 E.	re, Mai North	Avenu	
cian ilua iner	tmmed diseas resultii	liate Cause ( e or condition ng in death)	Finat	STAPHYI	OCOCCUS RDITIS	AUREUS		A COMPLICATIO	NG		Ons	set and Death
EXAMINIE	if any,	ntiatly list cor teading to im Enter Unde	mediate	b	Due to (c	or as a consec	uenca of):		m,	ME.		340
Madion	that ini	(Disease or tiated events ng in death) L		С.	Due to (o	r as e conseq	uence of):			1,2-6		
1	1			d							Ì	
Divisely	Ě	Other signifi	icant conditions	contributing to de	ath but not res	ulting in the u	nderlying cause	given in Pert I.		Yes 2 No	ontributs to the	cause of death?
ad Dy										an eutopsy	24b. Were a	utopsy findings le prior to
(	Daladina								pan	ormed?	compte of deat	tion of cause
-	Ē								113	Yes 2□No	Miye	s 2 No
		s case refer	red to medical					26. Place of Dea	V		7-1	
400	D exe	miner? Yes 2		Hospital:	npatient 2 🔽	ER/Outpatier	at 3D DOA	Whor:			ner (Specify)	
Campillantian T		nner of Deett Netural		28a. Dete of (Mont)	of Injury h, Dey Year)	28b. Time o	28c. tn			how injury occu	Other (Specify)	
100	3	Accident Suicide	6 Could not I	28e. Placa	of Injury - At h	ome, farm, st	eet, factory, offic		28f. Location	Street and Num	ber or Rural Ro	ute Number,
And a	4	Homicide	Gergiiiii)90	buildir	ng, etc. (Specil	(y)			City or To	wn, Stete)		
O look	29a. C	ertifier Check only one)	1 Certifying P	hysician: To the miner: On the ba and mann	sis of examina	wledge, death	n occurred at the vestigation, in m	time, date and place y opinion, death occu	, and due to the rred at the time,	cause(s) and m date and place,	anner es stated and due to the	i. cause(s)
Part of Section 1		,	title of certifier	and math	or stated.			ense number	number 29d. Date signed (Mo			
	1		1	MI	1.11	,	OCI				ER 30,	
			4/	11111	1						211 30 ,	
	30. Na	me and addre	ess of person who	completed caus	e of death (Iter	n 23a) (Type,	Print)					
	24.0	J.F.	+(K PYI)	111471	111),	111 P	enn Str	eet, Balti	more. M	arvland	21201	
State	31. Da	A L	n. Day. Year) N 0 5 20	01 32	egistrar's Signa	B	Spark			-		
gistra	11.0			1			//	_				

DHMH 16 Rev 6/95

ORIGINAL



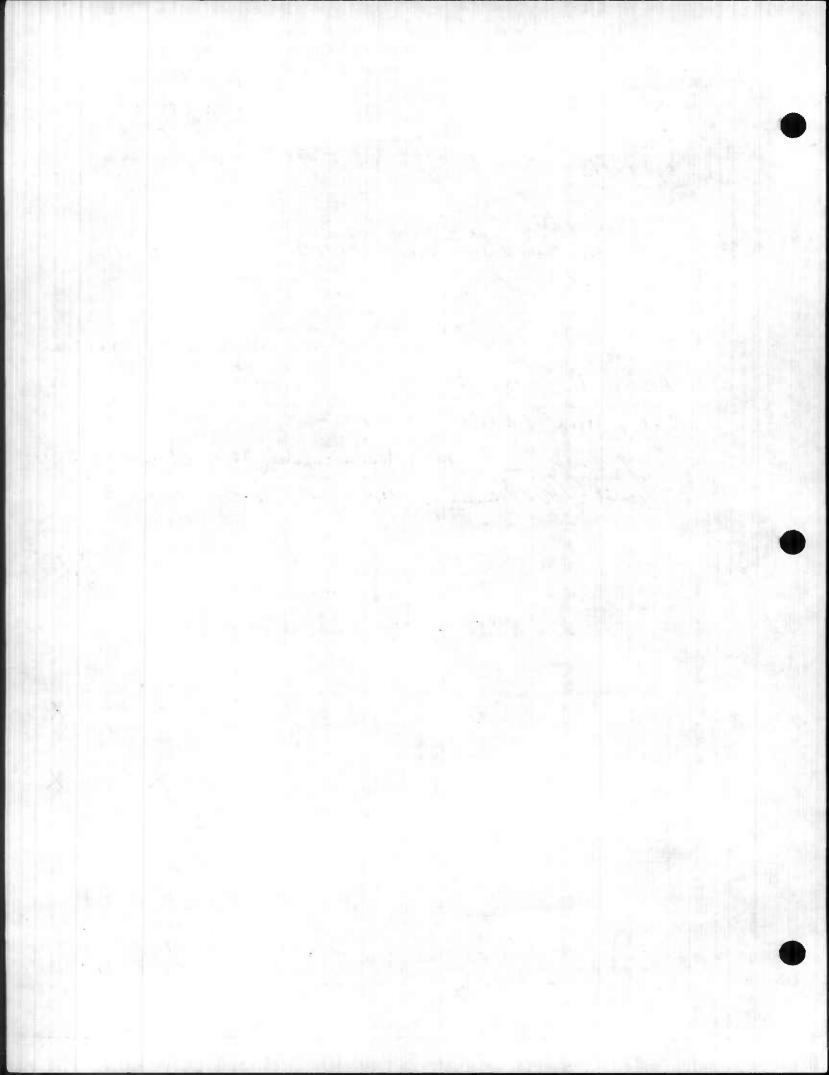
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Dete of Deeth Month 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Yeer **Physician** ARNEAUD WILFORD 5:46 P.M. 27, 2000 4c. County of Deeth DECEMBER /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner HOSPHUL FREDRICK, CO. Memorial REDRICK If Under 1 Yeer Months Deys 9. Birthplace (State or Foreign Country)
New YOHC 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Sociel Security Number **Funeral** 130187484 Hours 10M 20F Director Usual Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No FREDRICK MARYLAND Director 10e. Street and Number 5114 10f. Zip Code 10g. Citizen of Whet Country? must be n 21702 USA Heather Ridge DRIVE 1000 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Stetus 12. Wes Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Yeer or Detes: the Medical Examiner 1 Never Merried 2 Merried Specify: BLack 1 Yes 2 No Specify: ò þ 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry United Beotherhood of Carpenter Elementery/Secondery (0-12) College (1-4or 5+) Carpenter 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Be should be ind Mental Wilford ARNEAUd FERM is marked 7 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Pages 1 and 2 ament of Health an 1000 Heather Ridge Apt 5114 Fredrick MD permit. Pages 1 and 2 Department of Health a Important: If Item 27 is Wiltord CORA 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Methed of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete
4 Donesion 5 Other (Specify) MD Veteran Omentey 2/01 Owings mills, MI) 5 Other (Specify) Metropolitanchapel P.C. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical ASYSTOLE 30 min Examiner Due to (or es e consequence of): Physician/Medical Examiner INFAROTIO, MYOCARDIA certificate be executed attending physicien and for use as the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Lest CARDIO - JASCULAR DUEASE BRTERIOSCLEROTIC Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown C þ 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? this certificate has ral director, page 2 2 No 1 ☐ Yes 2 No Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☑ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 hours after deeth.

neral Director: After this y filled in by the funeral di 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. injury et Work? or Attanding 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 C-crtifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated. Medical completely (Check only one) 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 1058 140 15051. 30. Name and address of person who completed ceuse of deeth (item 23a) (Type, Print) . VICE - PRES MED AFFAIRS 4.0 Shire 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State oaks Registrar

**ORIGINAL** 

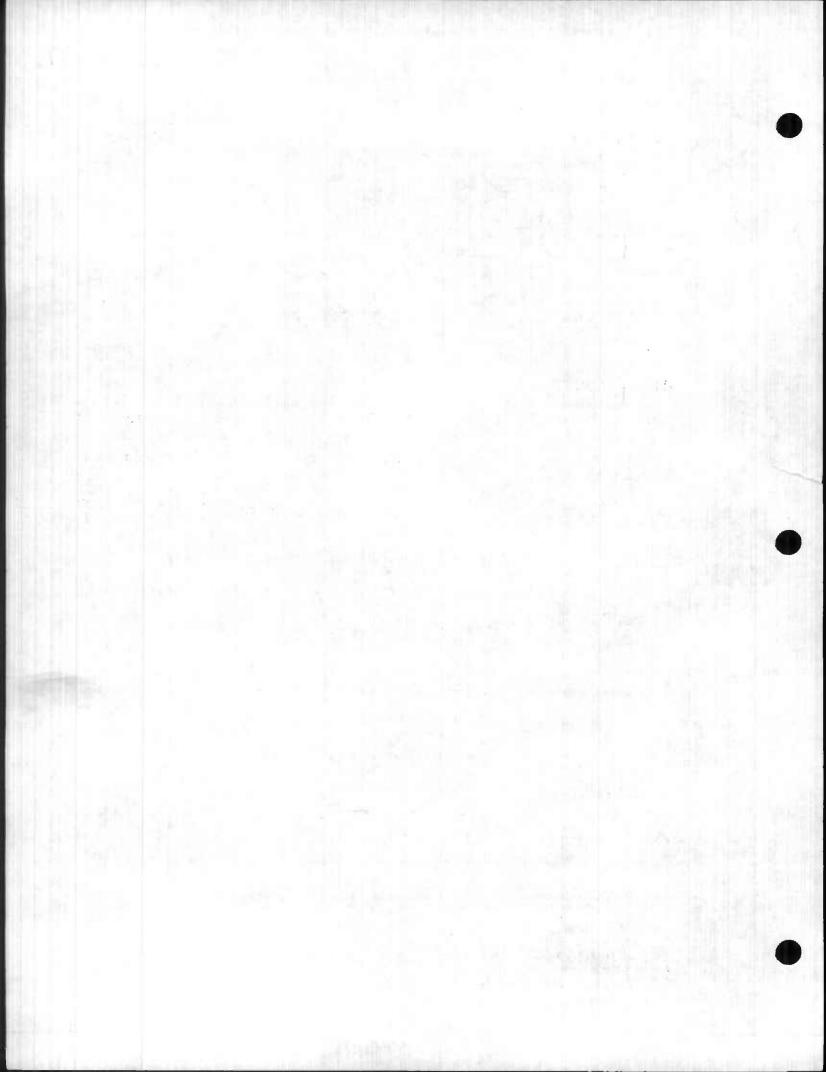


## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ician		cedent's Nem	ne (First, Midd Blair	- 100					-		2	Date of De	Day 3-2000	Year	3. Time	of Death
dical niner			'If not institution			nber)			4	4b. City, Town,	or Loca			y of Death		Jaill
mner			on Ave						В	altimor	e		Balti	imore	9	
al or	21	cial Security N	2096	6. Sex	M 2□F	7. Age (In yrs 72	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 H	tin.	Date of Bird (Month, Da 12-25-	1928	9. Birth Con KY	hplace (Stat untry)	e or Foreign
	_	I Residence o	10b. County	у		10c. C	ity, Town or Lo	ocation							10d. Inside	City Limits
<b>Funeral Director</b>	MI		Balti	more	2	Bal	timore								1 🗆 Y	es an No
1	10e.	Street and Nu 009 Elt	on Ave	enue				10f. Zip 2122					10g. Citizen of USA	What Co	untry?	
	1	_	ried 2 Kg Mar 4 □ Divorced	mied	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or De	ces? 2 No		Was Deced If Yes, spec		dispanic Originian, Mexican, Pr Specify:	(Speci uerto Ri	ify Yes or No can, etc.)	- 14. Ra Bia Specia	ck, White	ricen Indian e, etc. nite	
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	17. F		(First, Middle,							18. Mother's Rache			Maiden Surna			
	19a.	Informent's N	leme/Relation	ship (Typ		Mary 1				and Number of						
	-		ry Fran	nces	Blair	last	1009 Place of Dispo			renue, I	Balt					
	1		sposition Cremation 5 Other (		emoval from S	State	cometery, crei	matory or of	ther plac		12	Date /30/00	20c. Location  Balti			
		In	uneral Service	-	1					ss of Facility	1	**	D A			
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Medical Examiner	Sequif any cousthat in result	ediate Cause ase or condition	(Finel on on on on on on on on on on on on on	b c.	cations that control of the causedon of the ca	Due to Due to	ith. Do not ent	201 Dr. Iter the mode  COCU quence ot):  YUTU quence of):  Alm	unda le of dyir	PULM	diac of	Balti respiretory a	more, M		1222 Approxir Interval I Onset as	Between
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DHMH 16 Rsv 6/95

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State of Maryland / Department of Health and Mental Hygiene 0 1.2000

						Ce	ertificate	of	Death		Reg. No	) U 0.	42	00	0
Physicia		Decedent's Neme (First, Middle     James	e, Lest)	B	asket	te			Jr.	2. Dete of D Month December	De		Year 2000		of Deeth
/Medic		4a Facility Name (If not institution	a aive street end nu		asket			T	4b. City, Town, or			c. County		11:	10 A.M
Examin	er	John Hopkins B		9.1	al Cer	tor			Balti	more			N/A		
Funeral Director		5. Social Security Number 213-72-0906	6. Sex 1 M 2 □ F		(In yrs. last		If Under 1	Year			irth ley, Year 24			ice (Stelly)	ta or Foreign
v		Usual Residence of Decedent													
offin the Marylan r or 28a-f show be notified at	tor	Md Balt	imore		10c. City, To								10		e City Limits
r 28	Director	10e. Street and Number	11 21 -1 -1				10f. Zip C	ode			10g. C	itizen of V	Vhat Count	ry?	
A SE		7021 Dunbar	Rd.				212	22			1	USA			
urs after deat aft, or items 2 Examiner, ma	by Funeral	11. Mentel Status  1 Never Merried 2 Marr 3 Widowed 4 Divorced	12. Wes Dec Armed Fo 1  Yes If Yas, Gi Year or D	2 N		13.	. Wes Deceder If Yes, specify		Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	0-		e - America ck, White, e	itc.	e
Par Tar	pet	15. Decedent	's Education		16	Sa. Dece	edent's Usuel (	Occup	pation	rkina	16b. I	Cind of Bu	usiness/Ind	ustry	
S wthin jone. rrthan 'r	Be Completed	Elementery/Secondery (0-12)	+) S		ck Per		during most of wo	inny	Su	perm	arke	t			
off and	0 0	17. Father's Neme (First, Middle,	Last)						18. Mother's Ne	me (First, Middle	e, Maide	n Sumam	10)	-	
lid by florita fice and fice and	To B	James Basket	te S:	r.					Ruth C	lark					
Midt should be stand to the sta		19e. Informent's Name/Reletions Tena Baskett		ife					Rd. Du					Code)	
Pages 1 av		20e. Method of Disposition  1 Burial 2 Cremetion  4 Donetion 5 Other (S)	3 □Removel from	Stete	20b. Place ceme	of Disp stery, cre	osition (Neme emetory or other	of er ple	ece)	Dete Dec 30 2000	20c. L	City or Tov			
parmit. Departrimportu any inja		21. Signeture of Entheral Service	Licensee	7		C		ly	ess of Facility Funera lers Po	l Home	of	Dun	dalk	, P.	Α.
Physician /Medical Examiner		23e. Pant / Enter the diseese, or shoot, or haart failura. List  Immediata Ceusa (Final diseasa or condition resulting in deeth)		ecti	ensive	o not er	andio	of dyi	ing, such es cardia	c or respiretory	errest,	11109		Approxir Intervel	2122 mata Between nd Deeth
	Jer			[	Due to (or es	e conse	equence of):								
cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	Ь		Oue to (or as	e conse	equence of):								
1 0 0	Medical	that initiated evants resulting in death) Lest	d	C	Due to (or es	e conse	equence of):								
deeth cer e attendir	clan									1				• • • • • • • • • • • • • • • • • • • •	44.00
that the d	/ Physician/	Pert II. Other eignificant condition  Morbio				g in the	underlying cau	ise gi	ven in Pert I.		22 No			se of death?	
requires	Completed by									ber	s an aut formed?	1	con	ilable pri	osy findings ior to of cause
2 6 6	Con									15	1⊠ Yas 2		Eller and the second		2 No
slan: T	Be	25. Wes case referred to medical examiner?							26. Placa of De	of Death (Check only ona)					
_ 0 % 0															

Division of Vital

To the Hospital or Attending Physicial within 24 hours after death.

To the Funeral Director: After this certiconneletely filled in by the funeral direct

State Registrar

Certification: To

Stephen 31. Dete filed (Month, Day, Year) JAN U Ö

29b. Signeture end title of certifier

1X Yas 2 No

5 Pending Investigation

6 ☐ Could not be datarmined

27. Mennar of Death

1 Neturel
2 Accident

3 Suicide

29a. Certifier (Check only one)

28a. Data of Injury (Month, Dey Year)

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28e. Place of Injury - At homa, ferm, street, factory, office building, atc. (Specify)

28b. Tima of Injury

29c. License number

1 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, daath occurred at the time, date and plece, and due to the cause(s) end menner stated.

28c. Injury at Work?

1 Yes 2 No

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 28, 2000

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

30. Name and address of person who complated cause of deeth (Item 23a) (Type, Print)

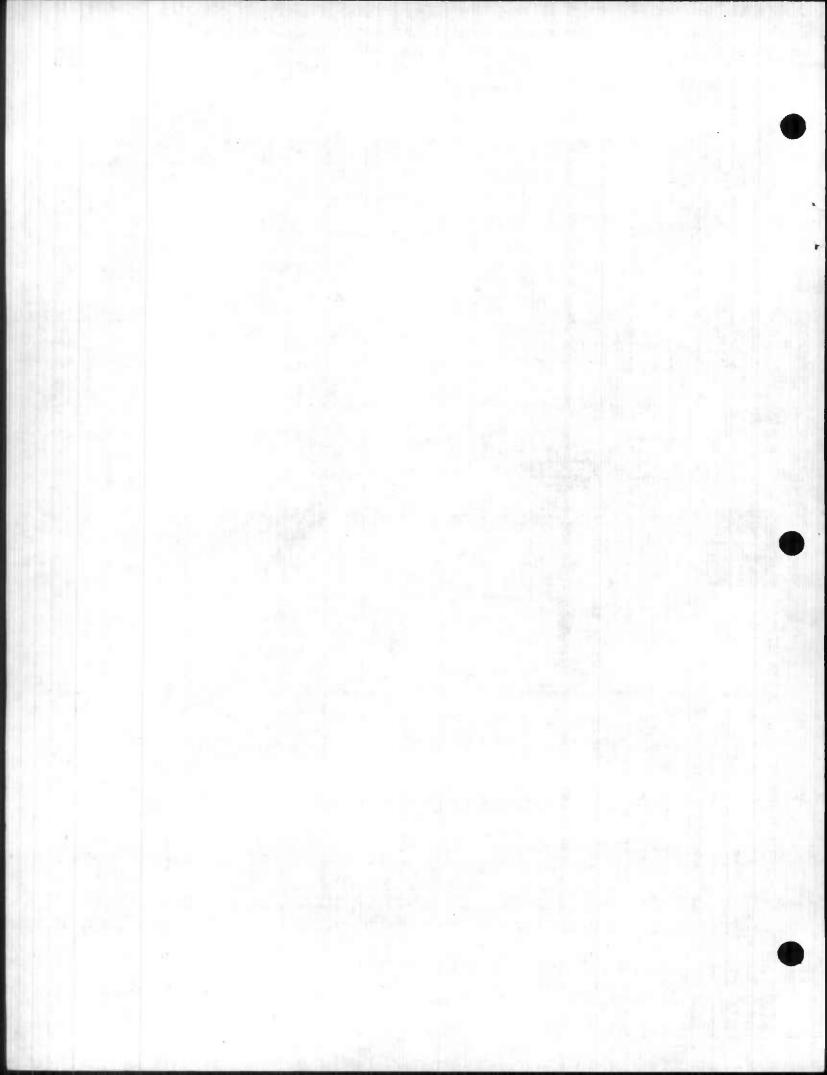
111 Penn Street, Baltimore, Maryland 21201

Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify)

28d. Describe how injury occurred

Radentz 32. Registrer's Signature

**ORIGINAL** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 1 Month 3. Time of Death Year ROBERT - L BV Facility Name (If not institution, give street and number) 2000 -20 Pm 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore Bon Secour Hospital N/A If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Deys Months Hours 15 M 2 F Mary Land **Yrs** 38 Oct. 4, 1962 Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits MD 1 1 Yes 2 □ No N/A Baltimore 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 3213 Westwood Avenue 21216 USA 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10th Laborer Building 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert Lee Butler Agnes McCready 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamera L. Butler / Sister 2920 Baker Street Baltimore, Maryland 21216 ce of Disposition (Neme of Dete 20c. Location 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Surial 2 Cremetion 3 Removel from Stete Western Star Cemetery 12/23/00 Baltimore, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility Gary P. March Funeral Home P.A. 270 Fred Hilton Pass Baltimore, Md Gary P. March per DVR 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth Due to (or as e consequence of): Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MMYNE DEFICIENCY DISORDER 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en autopsy performed? 200 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 | Homicide

death certificate be executed pur the attending physician hed for use as the burle signed by 9 Records, peen To the Hospital or Attanding Physicians within 24 hours after death.

To the Funeral Director: After this certificate has increase the funeral director, page 2 of Vitai

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or hams 23a or 28a-t show the Medical Examinar must be notified at

hours after

72

filed within

Pages 1 and 2 should be fill ment of Health and Mental H ant. If Item 27 is marked off

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and a

Departr Import any in

Physician

/Medical Examiner

Physician/Medical Examiner

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Certification: To

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Director

Funeral

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29a. Certifier 1 Authoring Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner steted. (Check only one) 29b. Signature and title of certifier

29d. Dete signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) · PRABHAKAR MD

ARMORY PLACE RAL, MO21201

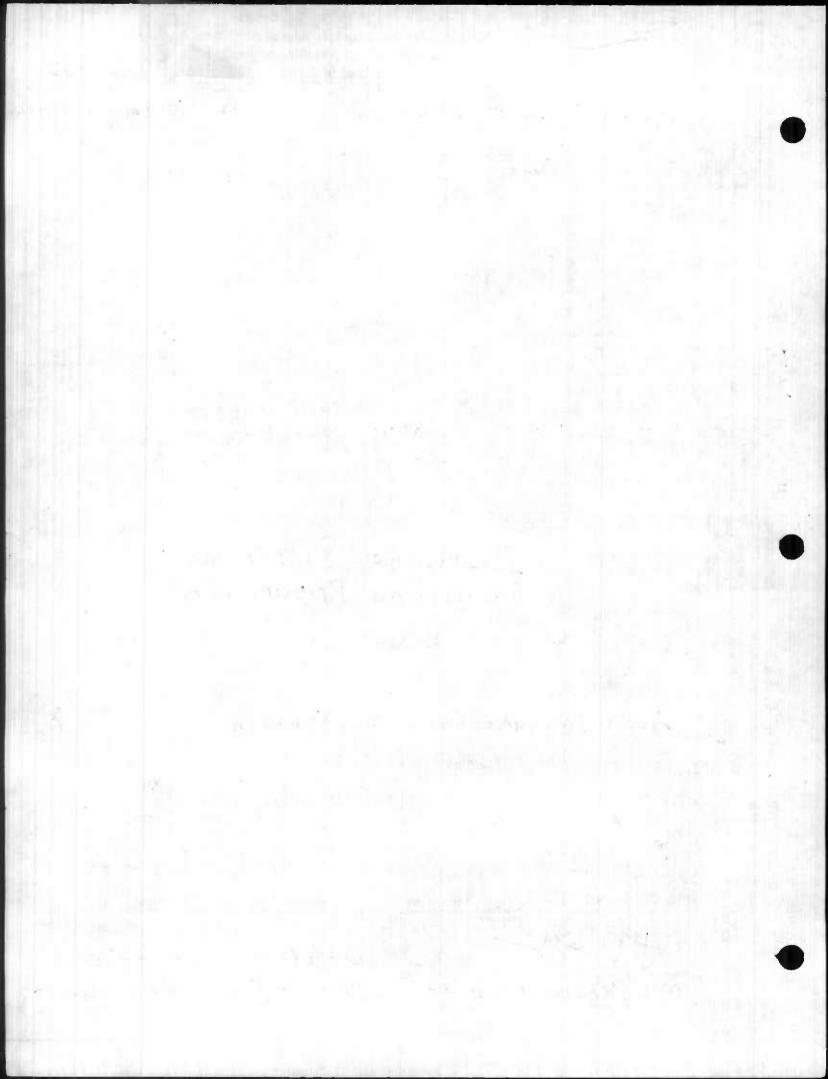
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State Registrar

31. Dete filed (Month, Day, Year) JAN 0 8

32. Redistrer's Signeture

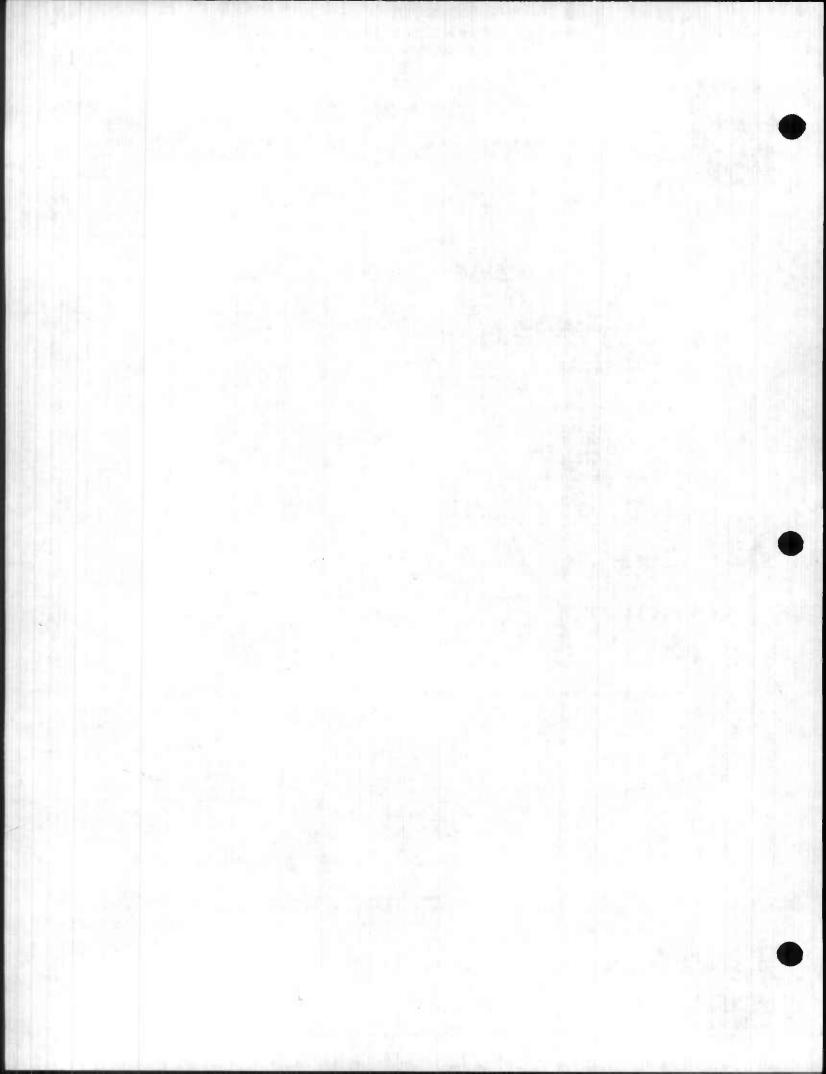
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#### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Year Month Physician **Nora Catherine Burke** 7:50 p.m. Dec 30, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner **Baltimore** Catonsville Mariner Health of Catonsville If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) Date of Birth (Month, Dev. Year) **Funeral** Days 10 M 20 F Months Hours Director 96 212-22-7471 Jun 16, 1904 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or flams 23e or 28e-f show the Medical Examiner must be notified at 1 Yes X2 No Directo **Baltimore** Catonsville Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21228 U.S.A. 98 Smithwood Ave Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, 12. Was Decedent Ever In U.S. Armed Forces? 11. Meritel Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 72 hours after 1 Never Merried 2 Merried 1 ☐ Yes Q☐ No Specify. Baltimore, Maryland 21215-0036 Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Hygians. Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker unk marked other 18 Mother's Name (First Middle Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If hem 27 is marked oths any injury or other traumatic event 17. Fether's Neme (First, Middle, Last) Be Margaret McNamra Thomas Lyons 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 1125 D'Long Rd. Apt D. Catonsville, Maryland 21228 Mr. James M. Burke 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1. Burial 2 Cremation 3 Removel from Stete
4 Donation 5 Other (Specify) 01/04/01 Baltimore, Maryland **New Cathedral Cemetery** 21 Signature of Funegai Service Licenses 22. Neme and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MO0538 art1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Infraediate Cause (Finel sease or condition esulting In deeth) /Medical Examiner Physician/Medical Examiner 10 The law requires that the death certificate be executed physician end the burial-tran Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence P.O. Box 68760 attending p USB 88 ed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 22 No 3 Probably 4 Unknown Records, p 24b. Were autopsy findings available prior to completion of ceuse of death? should l 24a. Was an autopsy performed? Completed page 2 s 21 M 1 ☐ Yes 2 ☐ No certificate 1 Yes Division of Vital Physician: 25. Wes case referred to medicei examiner? Be 26. Place of Death (Check only one) 20 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation To the Hospital or Attending 1 Natural death. 1 Yes 2 No 2 Accident Director: / 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) after 4 Homicide within 24 hours a To the Funeral C completely filled 29e. Certifier edical (Check only 29b. Signature end title of curlifier 29c. License number 29d. Date signed (Month, Qay, Year) Mysi Cin 1 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Allow evene MATZO (W) no 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State JAN 08 2001 anks Registrar

**ORIGINAL** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#23a perPHYG791 1/8/2001 EW 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death DECEMBER 19, 2000 **JEROME** COLLIDGE 4:45PM 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ST. ELIZABETH NURSING CENTER BALTIMORE If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) AUG. 27, 1937 5. Social Security Number 6. Sex 1M M 2□ F 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Months Deys Hours 63 Yrs. 216-34-4344 MD Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes alano BALTIMORE GLEN ARM 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code U.S.A. 16 GLEN ECHO COURT 21057 12. Wes Decedent Ever in U,S. Armed Forcee? 1 ☐ Yes 2 2 No If Yes, Give Year or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced WHITE 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com, rade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ DEVELOPER REAL ESTATE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) COLLIDGE CHARLES SHIRLEY KLOTZKIN 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 11964 THURLOE DRIVE - TIMONIUM, MD 21093 QASIM COLLIDGE / SON 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) WORKMENS CIRCLE CEMETERY 12/21/00 DUNDALK, MD 22. Name end Address of Fecility 21. Signeture of Funerel Service Licenses SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final diseese or condition resulting in death) heumosepsid Due to (or es e consequenca of): freumo ara Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Due to (or es a consequença of) DYSPHAGIA Due to (or es e consequenca of) Alzheimer 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings avellable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 DNO 1 Yes 20 No 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 Yes 2 HO 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

/Medical Examined physician and the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, for use as ed by the e been si page 2 s certificate Physician: After this Hospital or Attending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the lun

**Physician** 

/Medical

Examiner

**Funeral** 

Director

items 23a or 28a-f st iner must be notified

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Hygians. other than "nature ent, the Medical E

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Physician

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be nent of Health and Mental

Director

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Certification:

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29a. Certifier

(Check only one)

25. Wes case referred to medical examiner? 1☐ Yes 2☐ No 27. Menner of Deeth 1 Netural

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29b. Signature and title of certifie

29c. License number D33320

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner steted.

29d. Date signed (Month, Day, Year)

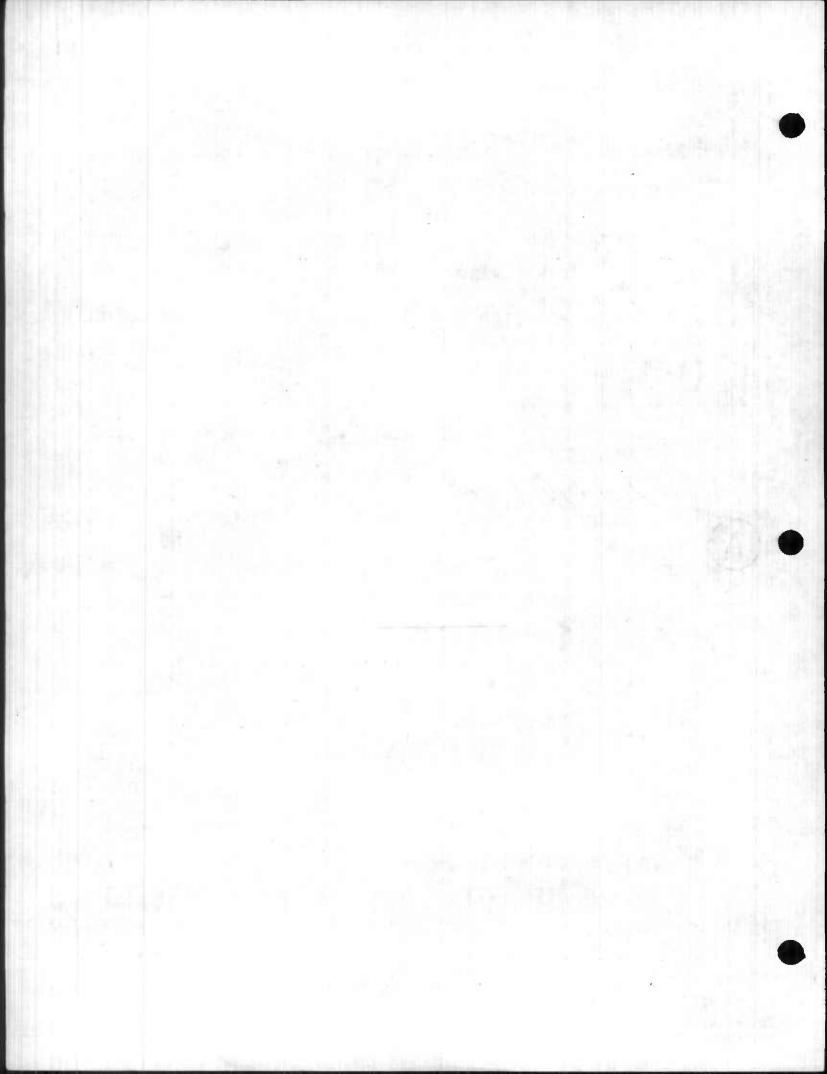
30. Name and address of person who completed cause of deeth (ftem 23a) (Type, Print)

MD. 210 Business Center Dr. Reisterstown MD 21136 Gloth II. 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

State Registrar

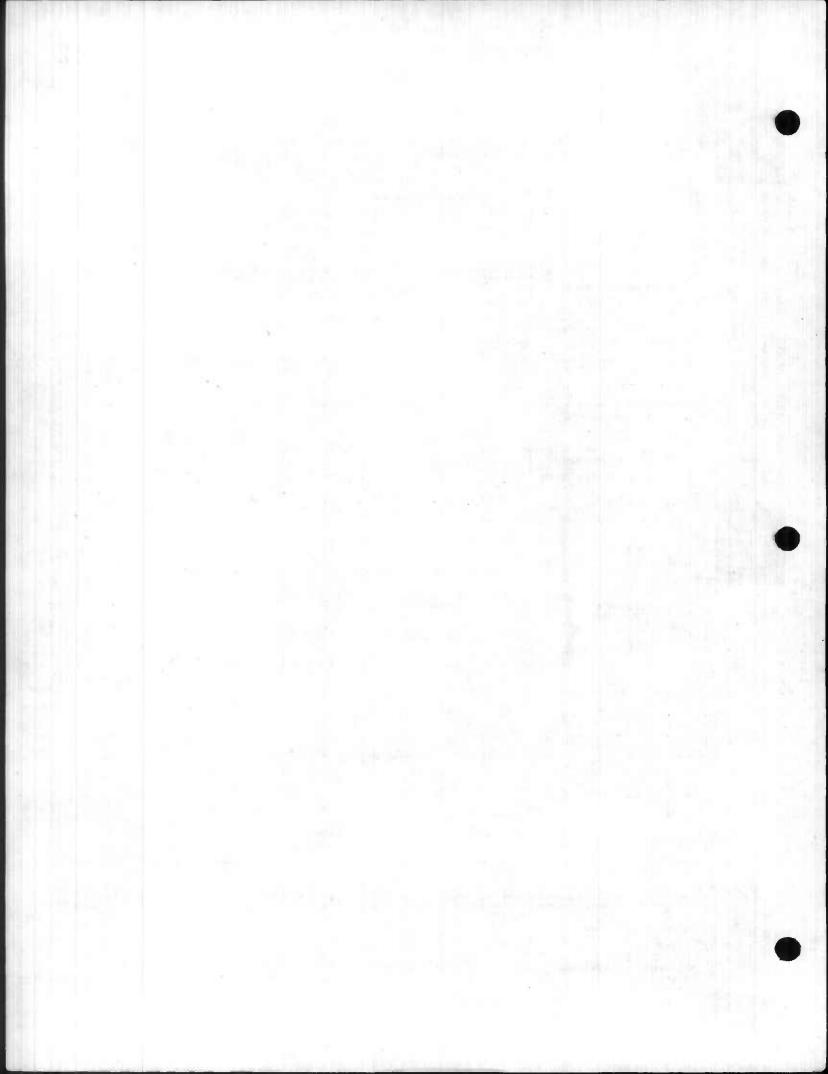
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**ORIGINAL** 



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Amended I	State of Mary tem#25 perPHYG791 1/8/2001 EW	land / Department of H Certificate of I		giene 0 42612
Physician /Medical	JAMES W. PANKHANEI.		2. Date of De Month DECEMB	Day Year
Examiner	4a Facility Name (If not institution, give street and number) National Lutheran Home		b. City, Town, or Location of Deat Rockville	Montgomery
Funeral Director	1010 07 07 07 07 07 07 07 07 07 07 07 07 07	yrs. last birthday) If Under 1 Year Months Days	Hours Min. 8. Date of Bir (Month, Date of Bir Jan 8,	9. Birthplace (State or Foreign Country)
Maryland H show	10a. State 10b. County 10c	c. City, Town or Location  Rockville	MANAGE	10d. Inside City Limits 1 ☐ Yes 2∑ No
offer deeth with the Ma writema 23e or 28e-fe from martle mothers	10e. Street and Number 9701 Veirs Drive	10f. Zip Code	20850	10g. Citizen of What Country? USA
Do.	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		spanic Origin? (Specify Yes or No n, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indien, Black, White, etc.  Specify: White
T C ' W G	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Unk  College (1-4or 5+)  unk	16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired Sal	furing most of working )	16b. Kind of Business/Industry
Battimore, Maryland 212: permit. Pages 1 and 2 should be flied withit Department of Health and Mentel Hygiens. Important: if fem 27 is marked other than any injury or other traumatic event, the language. To Be Comp	17. Father's Name (First, Middle, Last)		18. Mother's Neme (First, Middle Sophia M. Di	
and 2 sho salth and 1 n 27 le ma traums er traums	19e. Informant's Name/Relationship (Type, Print) Ruth Fankhanel/spouse		and Number or Rural Route Numberive Rockville,	er, City or Town, State, Zip Code) MD 20850
Baltimore, semil. Pages 1 at Department of He moortants if hen in in Injury or other nice.	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete  4 ☒ Donation 5 ☐ Other (Specify)	Ob. Place of Disposition (Name of cemetery, crematory or other place	e) Date	20c. Location - City or Town, State
Baltimo permit. Page Department important: If any injury or	21 Signature of Funedal Service Licensee Royald S. Wade, Direct	Baltimore,	MD 21201	W. Baltimore Street
Physician /Medical	23a. Part . Enter the disease, or complications that caused the mock, or heart failure. List only one cause on each sine.  Immediate Cause (Final disease or condition	death. Do not enter the mode of dyin	g, such es cardiac or respiratory e	Approximate Interval Between Onset end Deeth
Examiner	resulting in death)  Due	to (or es a consequence of):		weeks
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P.O. Box vat the death cert d by the attendin tetached for use Physician/M	Part II. Other significant conditions contributing to death but no			tobacco use contribute to the cause of death?
	Dail 1	12		Yes 2 No 3 Probably 4 Unknown an eutopsy 24b. Were eutopsy findings
The law requin	CAD			ormed? eveilable prior to completion of cause of death?
/lts	25. Was case referred to medical examiner?	Oth	26. Place of Deeth (Check only	one)
After After	1 Tes 2 No 1 Inpatient	28b. Time of 28c. Injury Work	4LQ.Nursing Home 5 ☐ Hest / et /? 28d. Describe /? Yes 2 ☐ No 28f. Location /	how injury occurred  Street and Number or Rural Route Number.
Hospi M. hou Funer Italy fill		pecity) knowledge, death occurred at the tirr	e, date end place, and due to the	wn, State)  cause(s) end manner es stated. date and plece, end due to the cause(s)
To the within 3 To the comple	296. Signafuer and title of calefiller W		3138	29d. Date signed (Month, Day, Year) Declar ben 30, 2000
State Registrar	30. Name and address of person who completed cause of death  Completed Cause of death  Completed Cause of death  31. Date filed (Month, Day, Year)  32. Registrer's S	19500 Amaro	eath Dr. Ger	maatown wb 20874
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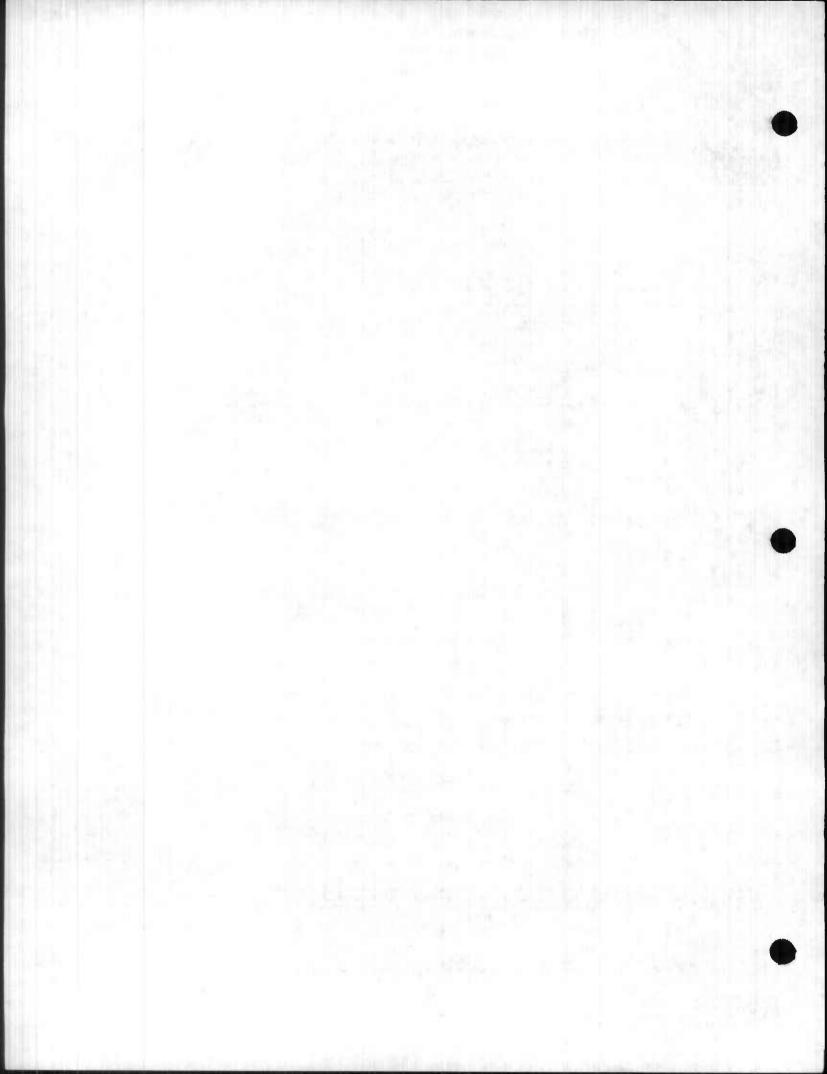
State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Dec DENNIE FRANKS 2000 30 39 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner COUNTY GENERAL HOSPITAL HOWARD HOWARD COLUMBIA If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplaca (Stete or Foreign Country) **Funeral** 1 M 2 F Months Nov 11, 1936 Director 230-42-9837 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐ No Director Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 20723 U.S.A Hygiene. other than "natural", or items 23a 9806 Gorman Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ☐XNo If Yes, Give Yeer or Detes: 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify White p 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene Important: if item 27 is marked other than "n any injury or other treumstic event Elementary/Secondary (0-12) College (1-4or 5+) Construction Supervisor 6 18. Mother's Name (First, Middle, Meiden Surname) 17. Fether's Name (First, Middle, Last) Be Martha Stanford Lloyd Franks 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) 9806 Gorman Rd. Laurel, MD 20723 Ms. Fannie M. Franks 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □xBuriel 2 □ Cremetion 3 □ Removel from Stete 01/05/01 Ellicott City, MD 4 Donation 5 Other (Specify) St. John's Cemetery 22. Name and Address of Fecility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 (moos 3.5 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) Ventricular librillation /Medical Examiner Examiner attending physician and for use as the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as e consequence of) Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 2 þ 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after deeth. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 28c. Injury et Work? 27. Menner of Death 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 - Homicide To the Hospital o within 24 hours af To the Funeral D completely filled i ACCITIFYING Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) end manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signatury and title of certifier 29c. License number Dec. 30, 2000 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) MAI-CHI NGUYEN, MD, olin 352 Drive 31. Date filed (Month, Da 32. Registrar's Signature , Year)

DHMH 16 Rev 6/95

Registrar

JAN 0 8 2001



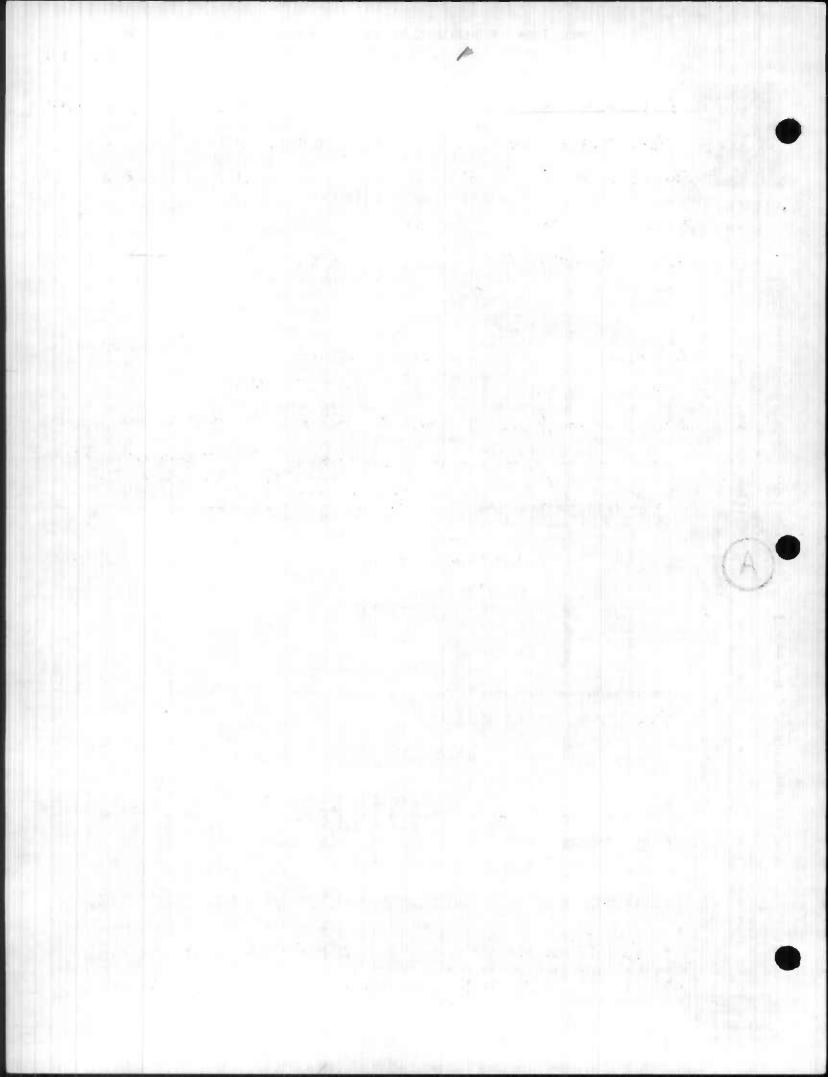
Item#1,10g State of Maryland / Department of Health and Mental Hygiene [] [] Amended Item#24a perPHYG791 1/8/2001 EW Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 3. Tima of Death Month Vaar **Physician** 700 December 6 Arthor G. Harris 2000 \* /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City 5. Social Sacurity Number Modical (enter Baltimore If Undar 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) If Under 1 Yaar 9. Birthplaca (State or Foreign 6. Sax 8. Data of Birth (Month, Day, Year) **Funeral** Months Days Hours 10M 2□ F 57 582 (3 890) Usual Rasidance of Decedan Director W.I. 890 Mar. 221943 JAMAICA the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at 1 Tras 2 □ No BALTIMORE Directo Mary And 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21215 AUG WSA Jamaica W.I 2528 BOARMAN Funeral 12. Was Decedant Evar in U,S. Armad Forces? 1 Yas 2 No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian 11. Marital Status Black, Whita, atc. Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 Widowed 4 Divorcad Black Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filled within:

Oppartment of Haalth and Mental Hygiene.

Important: If Item 27 ie marked other than "r

any injury or other traumatic event. In the Elemantary/Secondary (0-12) Collega (1-4or 5+) Grocery Store 12# grade MEAT CUTTON 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be HUBERT HAMRIS 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Park Ave Boltinon pd 2215 4/29 W. Forest Alther Williams / by cap 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata WOUDE PULL , Maryhous 4 Donation 5 Dothar (Spacify) Exton small Wood your Cometen 22. Nama and Addrass of Facility Cil ATM Br - HAT VIS F. H. 21. Signature of Funaral Sarvica Licansee 5240 REISTERSTUNN KUMO 23a. Part Inter the disassa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset end Deeth Physician a. Hepstorenal Syndrane
Dua to (or as a consequence of): /Medical Immediate Ceuse (Final 3 Weeks disaasa or condition rasulting in death) Examiner Examiner Henatilis Sequentially list conditions, if any, laading to Immadiata causa. Enter Undarlying Cousa (Disaasa or Injury that initiated events rasulting in deeth) Last Dua to (or as a consequence of): and Box 68760 physician Physician/Medical the Dua to (or as a consaguanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? P.O. 1 Yes 2000 á 3 Probably 4 Unknown Pancytopenia signed to Division of Vital Records, à 24b. Wara autopsy findings available prior to 24a. Was an autopsy Completed complation of ceusa of death? 1 Yas 2 □ No 1 Yas 2 No I or Attending Physician: after death. Director: After this certific 25. Wes case referred to medical axaminar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funaral 27. Mannar of Daath 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 2 Accidant 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 28e. Pleca of Injury - At home, ferm, streat, factory, office building, etc. (Specify) 3 Suicida 6 Could not be determined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Dil completely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the ceusa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and manner stated. 29a. Cartifier Medical 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. Licansa numbar December 2, 2000 MD 30. Nama and address of person who complated ceusa of daeth (Item 23a) (Type, Print) 51. Weiner Dept of Medicine. Baltimore, MD 21202 31. Data filad (Month, Day, Year) 32. Ragistrar's Signatura State souls Registrar JAN 0 8 2001 **DHMH 16 Rev 6/95** 

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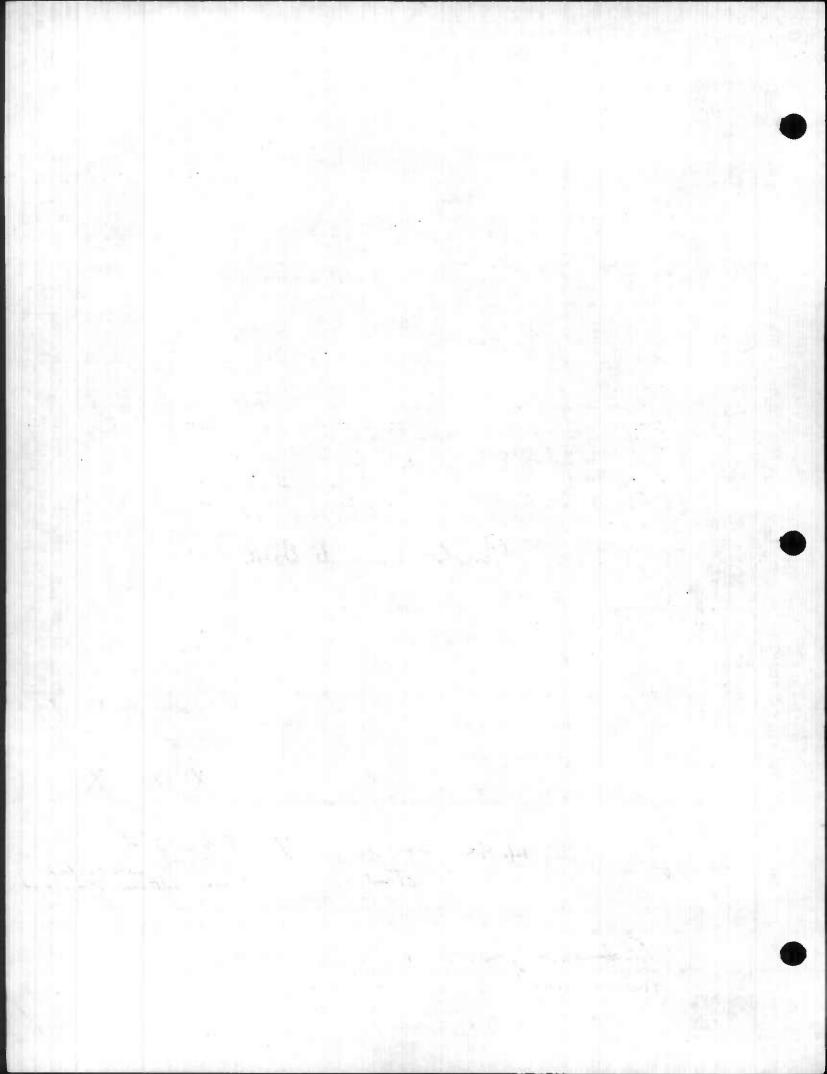


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **Physician** Dwight A . Harrel1 December 27, 2000 cation of Death | 4c. County of Death 2246 pm /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death Examiner Sinai Hospital Baltimore
If Under 24 Hrs. 1 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funerat Deys Hours Min. Months 1 M 2 F UAGROWN 25 Director 7/10/75 Baltimore, Md Usual Rasidence of Deceden 10a Stete 10d. Inside City Limits 10b. County 10c. City. Town or Location hams 23a or 28a-f st her must be notified 1 X Yes 2 ☐ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 4011 Oakford Ave. USA Funeral 11 Maritel Status 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 27 No 1 Never Merried 2 ☐ Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black If Yes, Gree Yaar or Datas: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed willnin Elementery/Secondery (0-12) College (1-4or 5+) Construction Worker Construction Co. 12 Hygir 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be the Department of Health and Mental Hy Important: If them 27 is marked oth any injury or other treumatic event Be Harrell Sr. Cynthia Hall A. Dwight 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Philadelphia, PA. 19136 4424 PennyPack St, CYNTHIA Hall Mother 20b. Plece of Disposition (Nema of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Deta ₩ Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 1/5/01 Lansdrown, Md. Mt. Zion Cemetery 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Estep Brothers Funeral Ser, P.A. 21217 1300 Eutaw Place, Baltimore, Md. 23a. Part1. Entar the disease, or complications that caused the deeth. Do not enter the moda of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be axecuted physician and s the burial-trana Sequentially tist conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Dua to (or es a consequenca of): resulting in death) Lest attending p 88 ed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? been si 24a. Wes an eutopsy performed? Completed page 2 hes 2□ No certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 0 1 Yes 2 No this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After or Attending 1 Neturel 5 Pending investigation Subject 1 Yes 2 No deeth. 2 Accident 12/27/00 2210 HR Director: / 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify) Homicide fin Oakford after strut avenue within 24 hours at To the Funeral Di completaly filled is 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 28, 2000 nes 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) THEI PURE M. KIN 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State JAN 0 8 2001 Registrar

DHMH 16 Rev 6/95



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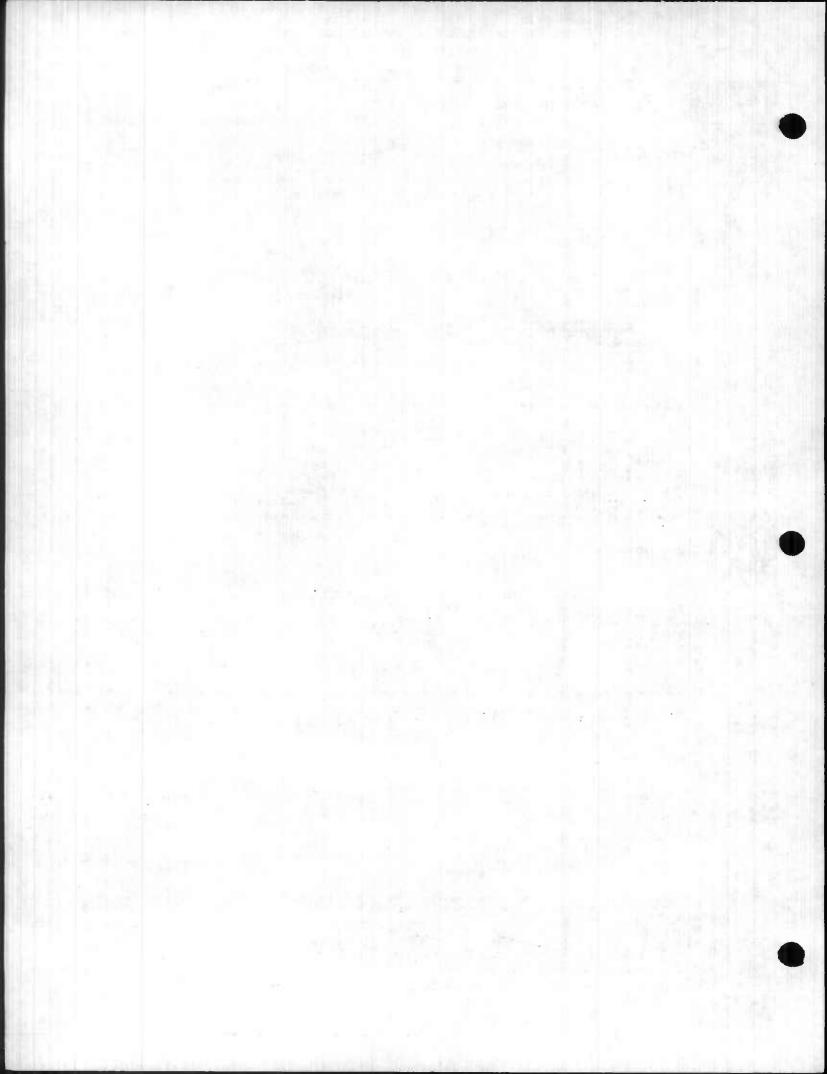
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** HURNER 10 7:05 PN DEC 29 2000 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examine Columbia 6213 Resting Sea Road If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 80 Director 579-22-0111 Sep 2, 1920 West Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√ Yes 2 No Directo Winchester Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or hams 23s or edical Examiner must be a 22603 U.S.A 1380 N. Hayfield Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes, 2 No if Yes, Give Yeer or Dates: 11. Maritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced I Hygiene. other than "naturn ent, the Medical I Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hyg important: if hem 27 is marked other any injury or other transmented other 2006. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 86 Janet Biggs William Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1380 N. Hayfield Rd. Winchester, VA 22603 Ms. Janet Grandstaff 20b. Plece of Disposition (Neme of cametery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 01/01/01 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) George Washington Memorial Park 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 N01113 23a. Fart 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, hock, or hear teilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical minutes Hemort Examiner Due to (or as a consequence of): Examine ears hosis 04 physician and s the bunal-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequenca of) Alcohol P.O. Box 68760. Physician/Medical Due to (or as e consequença of): resulting in death) Last attending ph by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 Heart Trisease signed to Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of deeth? thas been si Completed 24a. Was an eutopsy is certificate ha 1□ Yes 20 No 1 Yes 2 10 Physician: other Be 25. Was case referred to medical 26. Place of Deeth (Check only one) (gravel son) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) residence Yes 2 No 2 27. Manner of Death 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Seleturel 5 Pending investigation deeth. 1 Yes 2 No 2 Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in edical 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Deput Dec 30, 2000 21042 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Hemlock Cone Way Ellicottat MD PATRUCE A-T My 4565 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State

Registrar

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Joseph	C.	Jones

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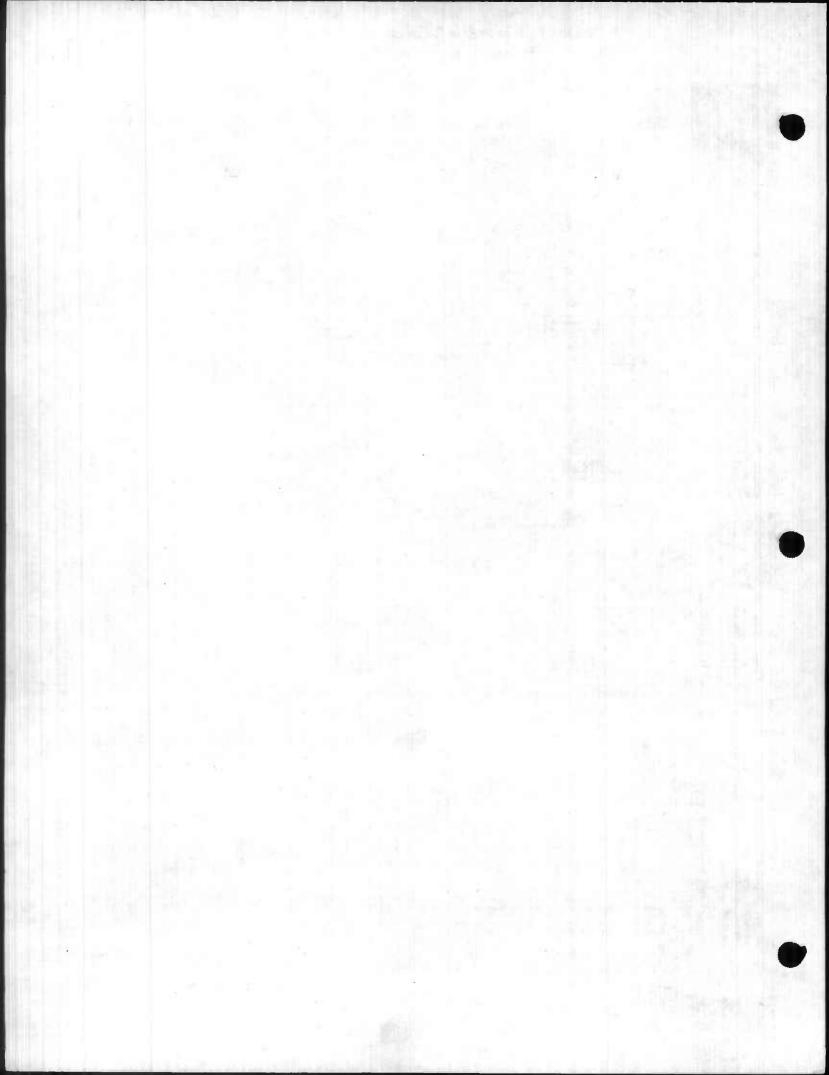
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31. Dete filed (Month, Pay, Year) 8 2001

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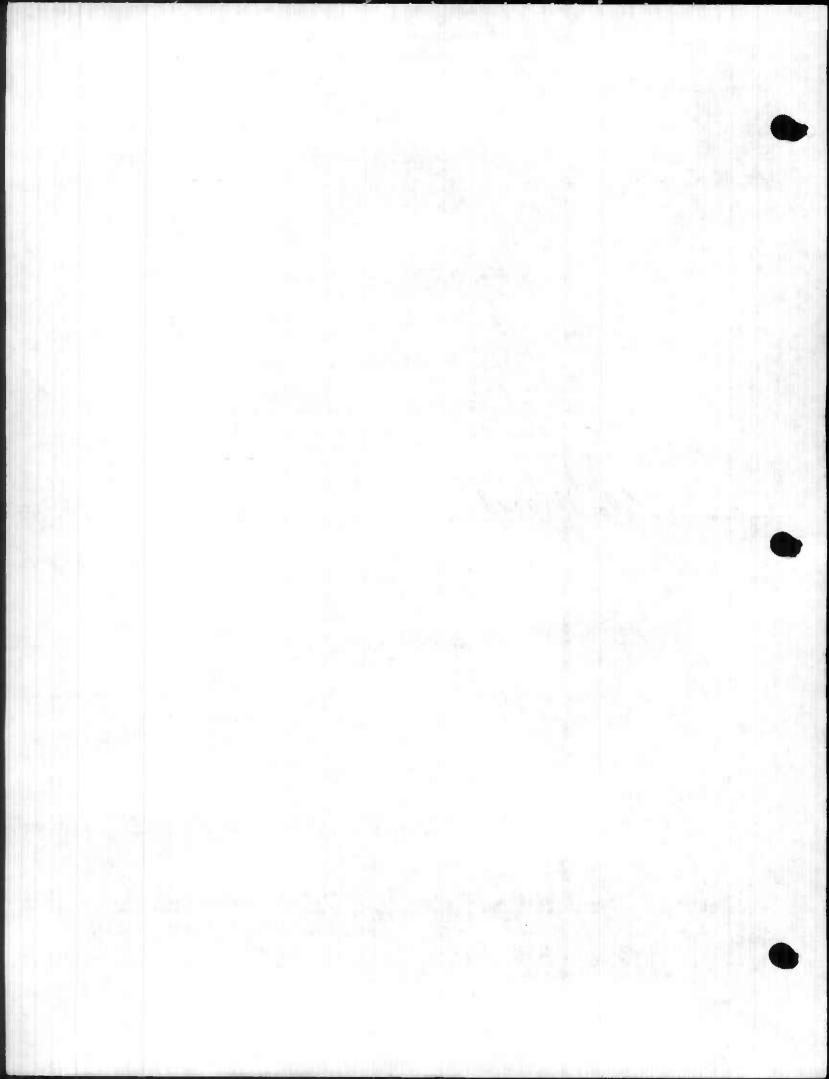
32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene amend item 16b per fh G791 1/8/01 yf Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** 12 30 2000 Joseph T. Johns 10:20 p.m. /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Nama (If not institution, giva street and number) **Examiner** Corsica Hills N/H Centerville Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (fn yrs, last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Months Days 1√ M 2□ F Director 76 8-27-1924 218-16-6962 Md Usual Rasidence of Decedant 10c City Town or Location 10d. tnsida City Limits 10a Stata 10b. County raf, or items 23a or 28a-f show Exeminer must be notified at 1 Yes 2 No Queens Anne Directo Grasonville 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? USA 210 Canal Street 21638 12. Was Decedent Evar in U,S. Armed Forcas? 1∑(Yes 2 □ No If Yas, Giva Yaer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, 11. Marital Status 1 Never Married > Merried Maryland 21215-0020 "natural", or 1 ☐ Yas 2 No Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast greda complated) Adberdeen Proving Elementary/Secondary (0-12) Collega (1-4or 5+) Aberdeen Ground 12th grade years Machinist 18. Mother's Name (First, Middla, Maiden Surname) Pages 1 and 2 should be 10 per of Health and Mental Hy E If Nem 27 is marked 17. Fathar's Nama (First, Middle, Last) and New Matthew Johns, Jr Bessie Johnson 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Rixcy Johns- Wife 210 Canal Street Grasonville, Md 21638 20b. Place of Disposition (Nema of cematery, cramatory or othat place)
Garrison Forest Veteran 1-05-01 20a. Mathod of Disposition 20c. Location - City or Town, Stata Pages tent of h 1 □ Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) Owings Mills, Md 21. Signature of Funaral Sarvice Licenses 22. Name end Address of Fecility
March F/H West 4300 Wabash Avenue Baltimore, Md 21215 23a-Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. **Physician** /Medical congestive heart failure Immediata Causa (Final month diseasa or condition rasulting in death) Examiner Examiner myocardia ettending physician and for use es the burial-trensit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disaasa or Injury that initiated evants rasulting In death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco usa contribute to the cause of death? renal failure, dialysis 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy tindings Completed 24a. Was an autopsy dependent eveileble prior to complation of cause of daeth? 1 ☐ Yas 2 ☐ No 25. Was casa retarred to medical axaminar? 26. Placa of Death (Chack only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 28a. Data of tnjury (Month, Dey Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? To the Hospital or Attending Privithin 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 1 Natural 2 Accident 5 ☐ Pending 1 Yes 2 No Invastigation 6 ☐ Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier (Check only one) fix Certifying Physician: To the best of my knowledga, death occurred at tha time, data and placa, and dua to the cause(s) and manner as stated.

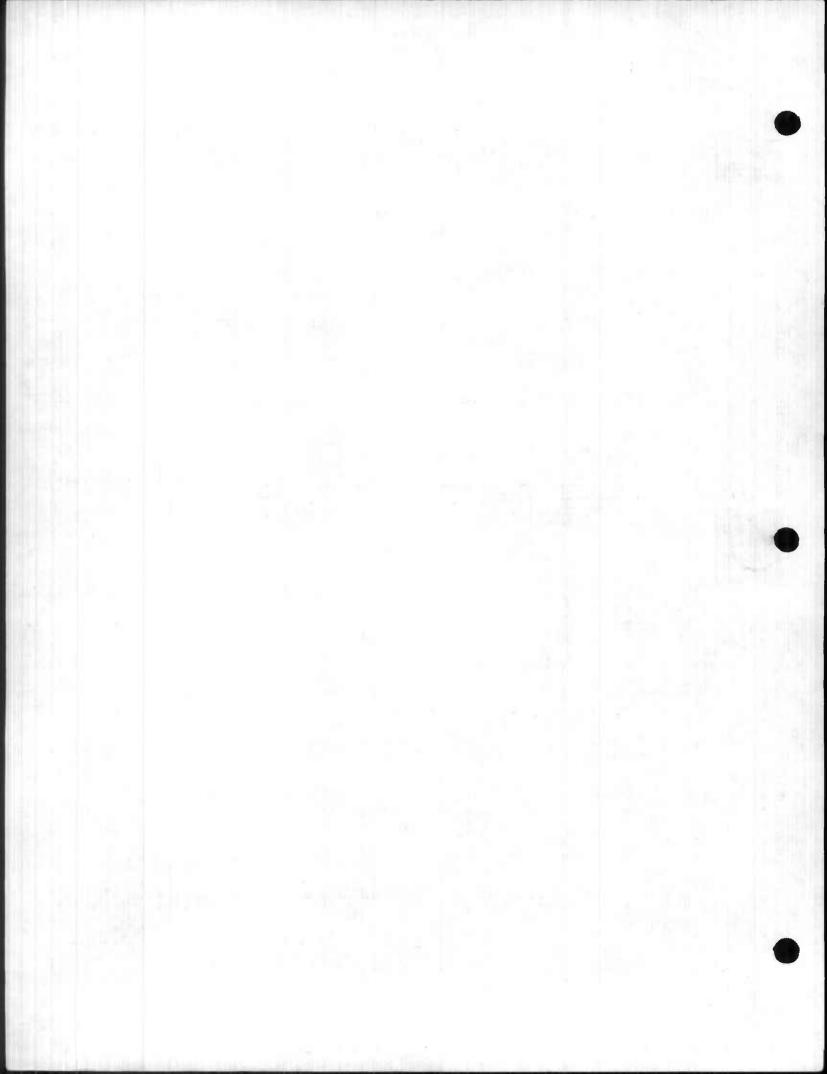
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner stated. Medical 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and little of cartifier D0029571 30. Name and address of person who completed causa of death (Itam 23a) (Typa, Print) Blyd suite 101 arofton Berez 1655 Crofton 31. Date filed (Month, Day, Year) 32. Registrer's Signature JAN 0 8 2001 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. amend item 9,11,12,15,16a,b19a,b,20a,b,c,21State of Manyland/Department of Health and Mental Hygiene Certificate of Death Amended Item#23a perPHYG791 1/8/2001 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** KANAR LILLIAN 1747 2000 Dec /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Regional Hospital Laurel Laurel If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 25, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F Deys Yrs 218-20-0161 1921 Apr Maryland Director Usuel Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at Prince Georges Laurel 1 Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20708 9001 Cherry Lane USA Funeral death Permit. Peges 1 and 2 should be filed within 72 hours after dear Coperment of Heelth and Mentel Hygiene.

Important: if item 27 is marked other then any injury or other traumers. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Nems unk 12. Wes Decedent Ever in U.S. Armed Forces? Unic 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married Yes 2 XNo Yes, Give 1 ☐ Yes 2 ☐ No Specify: white Specify: à 3 ☐ Widowed 4 ₺ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker unk unk 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 19e. Informant's Name/Relationship (Type, Print) unk 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1918 Greenstone Ct. Midway Park, NC 28544 Julia Jackson/daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Metro Crematory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Remoyal from State 4 ☐ Donation 5 ☐ Other (Specify) In State 12/29/00 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee Thomas Gregor Romald S. Wade, Director 22 Name and Address of Facility Cremation, Society of Md, State Anatomy Board 529 Frederick Road Inc. Street 21201 21228 Baltimore, MD 23a. Part En er the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heart failure. List only one cause on each line. tntervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ASPIRATION TERMINAL minule Examiner Due to (or es a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last bunel-tran and Due to (or as e consequence of): Box 68760. physicien the Due to (or es e consequenca of): USB BS P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HTA Anom, 9 Records, Š 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy After this certificate has 1 | Yes 2 | No 1 ☐ Yes 2 ZtNo of Vital Medicai Certification: To Be 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 TNo funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Attending 1 STATUTAL 5 Pending Investigation spital or Attendii cours after death. herel Director: A filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 24 hours 8 29a, Certifier 4☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29c. License number 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) D2-8998 Dec 7 2000 ritem S FRITAM SS AIRI MD 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 9101 cherry 20708 Suite LN 211 (aure) 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State parks JAN 0 8 2001 Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42620 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** 3.20 pm NANNIE KIOWELL December 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner 900 Agnes Hospital Caton Avenue Baltimore Himore If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Months | Devs | Hours | Min. | (Month, Day, 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 10 M 20 F Deys 220.2A.2466 Yrs. Director Usual Rasidence of Dacedeni 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No M BALTIMORE A 10a. Street and Number 10f. Zip Code 10a. Citizen of What Country? Dir 21228 DUNBAR AVENUE USA Funeral 12. Was Decedant Eyar in U,S. Armed Forcas? 1 Yas 2 No If Yas, Giva 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cyban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11 Marital Status 1 Nevar Married 2 Married Specify: BLACK 1 ☐ Yas 2 ☑ No Specify: 4 3 Widowed 4 □ Divorced Yaer or Dates: 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) COOK ALEX 10 TH GRADE NA BROWNS 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) LULA PARKS WILLE JONES 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship, (Type, Print) NANNIE WYCHE NIECE 9400 GADWELL TERR. CHESTERFIELD , VA 20c. Location - City or Town, Stata 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 101.05.2001 FREEMON, VIRGINIA 4 ☐ Donation 5 ☐ Othar (Specify) WION BETHEL CEMETERY 21. Signature of Funeral Sarvice Licenses 22. Nama and Addrass of Facility VAUGHN C. GREENE PLINERAL SERVICES 23a. Part 1. Enta Ma disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in deeth) /Medical Physician/Medical Examine h DUVS Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Ceusa (Disease or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequance of) Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to completion of ceuse of daeth? Completed 24a. Was an autopsy 2 No 2/2 No 1 ☐ Yas 25. Wes cesa rafarred to madicel Be 26. Placa of Death (Check only ona) exeminer? Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 Inpatient 2 ER/Outpetient 3 DOA 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? 5 Panding invastigation 1 Netural 2 Accident 1 Yes 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

Examiner certificate be executed NAME KIDWELL

physician end s the burial-transit 80 Pol ed by the a signed by this cartificate has ral director, page 2 Hospital or Attending Physician: 24 hours after death.

must be notified at

Nerna 23a

natural, or

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parmit. Pages 1 and 2 Department of Health v Important: If New 27 in any injury or other tra

Baltimore,

To the Hospital within 24 hours a To the Funeral Completely filled

State Registrar

29b. Signatura and titla of certifiar

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stelled. 29c. Licansa number

29d. Data signed (Month, Day, Year)

P13597

30. Nama and address of person who complated ceusa of death (Itam 23a) (Type, Print) lawu-Dike, M Maxins

Medicine, 900 Caton Are Baltimore

31. Data filed (Month, Day, Year)

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29a. Cartifier

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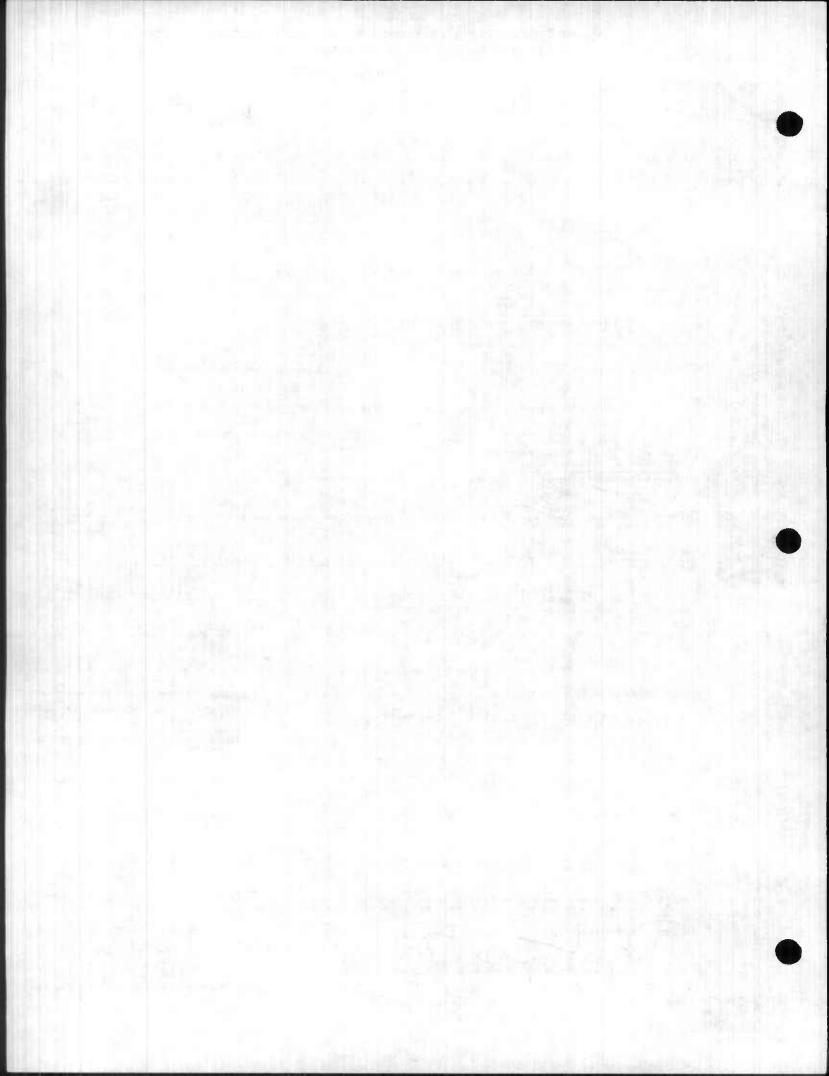
32. Ragistrar's Signatura

**DHMH 16 Rev 6/95** 

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State of Maryland / Department of Health and Mental Hygiene 00 42621

	Certificate of Death	Reg. No.
15-01-1	Decedent's Name (First, Middle, Last)	2. Date of Deeth Month Dey Yeer 3. Time of Death
Physician /Medical	Children OF I Core	Dec 27, 2000 13;25
Examiner	4h Cibe Tours	o, or Location of Death 4c. County of Death
	Howard County General Colum	
Funeral		Min. (Month, Day, Year) Country)
Director	215-22-1964 72 Yrs. Usual Residence of Decedent	Nov 27, 1928 Pennsylvania
P Au	10e. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
with the Marylar a or 28a-f show be notified at Director	Maryland Baltimore Baltimore	1 ☐ Yes 21 No
or 28et s be notified	10e. Street and Number 10f. Zip Code	10g. Citizen of Whet Country?
and the second		U.S.A.
har death theme 23 sher must	11. Meritel Stefus  12. Wes Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, is	
020 020 020 020 020	3 ☐ Widowed 4 ☐ Divorced Yeer or Detes:	Puerto Rican, etc.)  Bleck, White, etc.  Specify: White
21215-0 ed within 72 ho syjene. er than 'netur t, the Medical.	15. Decedent's Education 16e. Decedent's Usual Occupetion (Specify only highest grade completed) (Give kind of work done during most o	f working
2121 d within plans. r than it the life.	(Specify only highest grade completed)  (Give kind of work done during most of life. DO NOT use retired)  Elementery/Secondery (0-12)  College (1-4or 5+)	
d 2	12 4 Certified Nurse	Medical
land bill be fill be f	17. Father's Neme (First, Middle, Last)	s Neme <i>(First, Middle, Maid</i> en <i>Sum</i> eme)  Rominc
Ty house		
Mary and 2 should be set to a traumet		or Rural Route Number, City or Town, State, Zip Code) e, Baltimore, Maryland 21227
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Pag Pag Ment Ment Ment Ment Ment Ment Ment Ment	4 Donetion 5 Other (Specify) Meadowridge Mem. Park	1/3/01 Elkridge, Maryland
alt military inches	21. Signature of Funeral Service License 22. Name end Address of Fecility	
W 22122	Hubbard Funera	I Home, Inc. venue, Baltimore, Maryland 21229
	23a. Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as caused the deeth. Do not enter the mode of dying, such as cause on each line.	Approximete Intervel Between
Physician		Onset end Death
/Medical Examiner	Immediate Cause (Final disease or condition A therosclero tic Cardio	vascolar Discuse years
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Beath after d for all	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.	23b. Did tobacco use contribute to the cause of death?
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I Records, P.O. Box  The law requires that the death certain has been signed by the attending page 2 should be detached for use  Completed by Physician/N		24a. Wes an autopsy performed?  24b. Were autopsy findings evaileble prior to completion of cause of deeth?
f Vital Recognitions of the National Property		1 Yes 2 No 1 Yes 2 No
		f Death (Check only one)
of Vital Physician: T this certificat ral director, p		ing Home 5 ☐ Residence 6 ☐ Other (Specify)
0 5 5 8		28d. Describe how injury occurred
nding athorse for a for	1 Neturel 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No.	
Division of or Attending after death. Director: After d in by the funa.	3 Suicide 4 Homicide  6 Could not be determined  28e. Plece of Injury - At home, ferm, street, tactory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division of the or Attending Prisa after death.  The or Attending Prisa after death or the funers led in by the funers Certification:		
Division o  To the Hospital or Attending Ph within 24 hours after death. To the Fureral Director: After th completely filled in by the funeral Medical Certification:		
To the complete of the complet	290. Signature and title of certifier Deport 29c. License number	29d Date signed (Month, Day, Year)
- > - 0	1 1 MD MB D314	73 Dec 29, 2000
12/	30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)	21042
18-1	PATRYCE A. TOTE, MD 4565 Hemlock	Cone Way Ellicott City MD
State	31. Dete filed (Month, Day, Year) 32. Registrer's Signeture	
Registrar	JAN 0 8 2001 Deneva & Souls	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Year Month Mackinzie Marie 30 2000 4:30 PM December 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Westminster Nursing & Rehabilitation Westminister If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months 1□M 20 F Yrs. 216-32-0805 March 22, 1913 Maryland Usual Rasidence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Carroll 1 ☐ Yes 2 ☐ No Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4286 Harney Road 21787 U.S.A. 12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 11. Marital Status 1 Never Merried 2 Married 1 Yes 2 No Specity: Specify: White 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 0 Dietician Healthcare 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) Joseph Benesch Josephine (unknown) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) William C. Mackinzie, Jr./ Son 4286 Harney Road, Taneytown, Maryland 21787 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) Loudon Park Cemetery 1-3-2001 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Ceuse (Finel disaese or condition resulting in deeth) u Alsensi Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury Due to (or as a consequenca ot): CV thet initiated events resulting in deeth) Last Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings available prior to completion of cause of death? 24e. Wes en autopsy performed? 241 No 1 Yas 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28a. Data of Injury (Month, Dey Year) 27. Menner of Deeth 1 Netural 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work?

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23s or 28s-f show the Medical Examiner must be notified at

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Funeral

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physician and s the bunal-trans attending p usa as signed by the a been signated pega 2 s director, page this

Physician/Medical

by

Completed

Be

To

Certification:

2 Accident

4 Homicide

31. Date filed (Month, Dey, Year)

3 ☐ Suicida

29e. Certifier

lew requires that the death cartificate be executed Box 68760 Division of Vital Records, P.O. The Physician: Aftar this or Attanding deeth. Director: / aftar

To the Hospital o within 24 hours af To the Funeral Di Completaly filled in edicai

State Registra

29b. Signature and title of gertifier

5 Panding investigation

6 Could not be determined

29c. License number

1 Yes 2 No

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year)

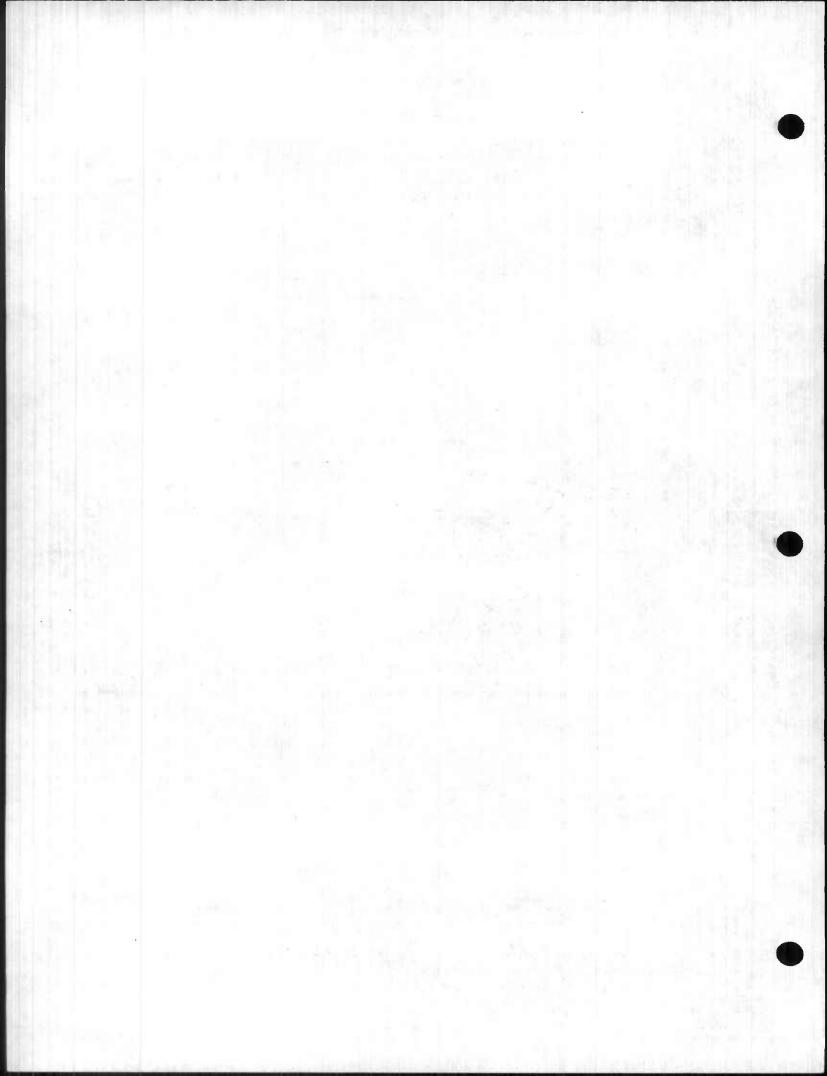
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who comp cause of death (Item 23e) Type, Print) 688 Poole Koad om Middleton

32. Registrer's Signeture JAN 0 8 200

oaks

Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Stewar 2227 so ber 2 31,2001 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Baltimore of N/A Sister Maryland Medical University If Under 1 Year 5. Social Security Number 6. Sax 7. Age (fn yrs. last birthday) If Undar 24 Hrs. 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) Months Days 110 M 2□ F Hours 212-12-9596 APRIL 13. MD. Usual Residence of Daceden 10c. City, Town or Location 10e State 10b. County 10d. tnslda Clty Limits MD. N/A 1 ♥ Yas 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 521 N. MOUNT ST. 21223 USA 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☑ Yas 2 ☐ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, Whita, atc. 1 M Never Married 2 ☐ Married 1□ Yes 2th No Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) -7-HOUSING AUTHORITY CITY OF BALTIMORE 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middla, Last) ROBERT WINFIELD TURPIN CATHERINE STEWART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DEBORAH BATES (DAUGHTER) 521 N. MOUNT ST. BALTIMORE, MARYLAND 21223 20a. Mathod of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stafe 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VETERANS 1-9-2001 OWINGS MILLS, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility BAILEY FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death Immediate Cause (Final diseese or condition resulting in deeth) 3 hrs Due to (or as a consequence of) Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Lasf Due to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? Artery Disease 24a. Was an autopsy performed? 2 No 1 Yes 2 No 25. Wes case referred to medical exampler? 28. Place of Death (Check only one)

**Physician** /Medical Examiner

Examine

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

rai', or items 23s or 28s-f show

\*natural', or

traumatic evant, the Medical

d 2 should be filed within 7: th end Mental Hyglene. 7 Is marked other than "ny

permit. Peges 1 and 2 should be file Department of Heelth and Mental Hyy Important: if Itam 27 is marked othe any Injury or other traumatic event, pages.

Directo

Funeral

by

Completed

the Meryland

72 hours after deeth

The lew requires that the death certificate be associted Division of Vital Records, P.O. Box 68760, peeu hes

Physician:

physicien end s the buriai-trens 80 attending p 980 ed by the a signed by t pege 2 certificate this funerai After t

Director: A

Physician/Medical þ Completed Be 2 Certification:

or Attanding after To the Hospital or within 24 hours aft To the Funeral Di completely filled in

State Registrar

Medical

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier

5 Pending Investigation

6 Could not be

Hospital:

28a. Dete of Injury (Month, Dey Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. Licensa number

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Dey, Year) January 2001

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

cause of death (Hom 23a) (Type, Print) W. Red wood St. Suite 280, Baltimore, MM 4/19 hve

31. Date filed (Month

1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicida

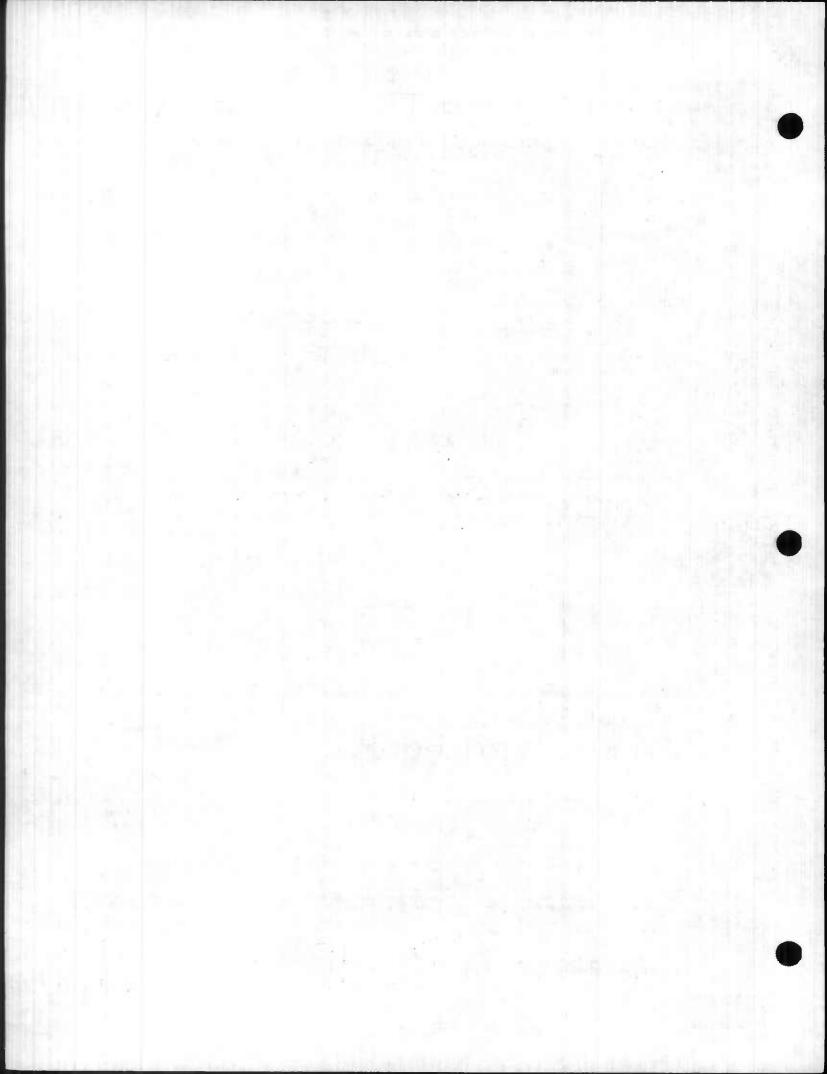
4 Homicide

32. Registrar's Signatura

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28c. Injury at Work?

1 Tyes 2 No



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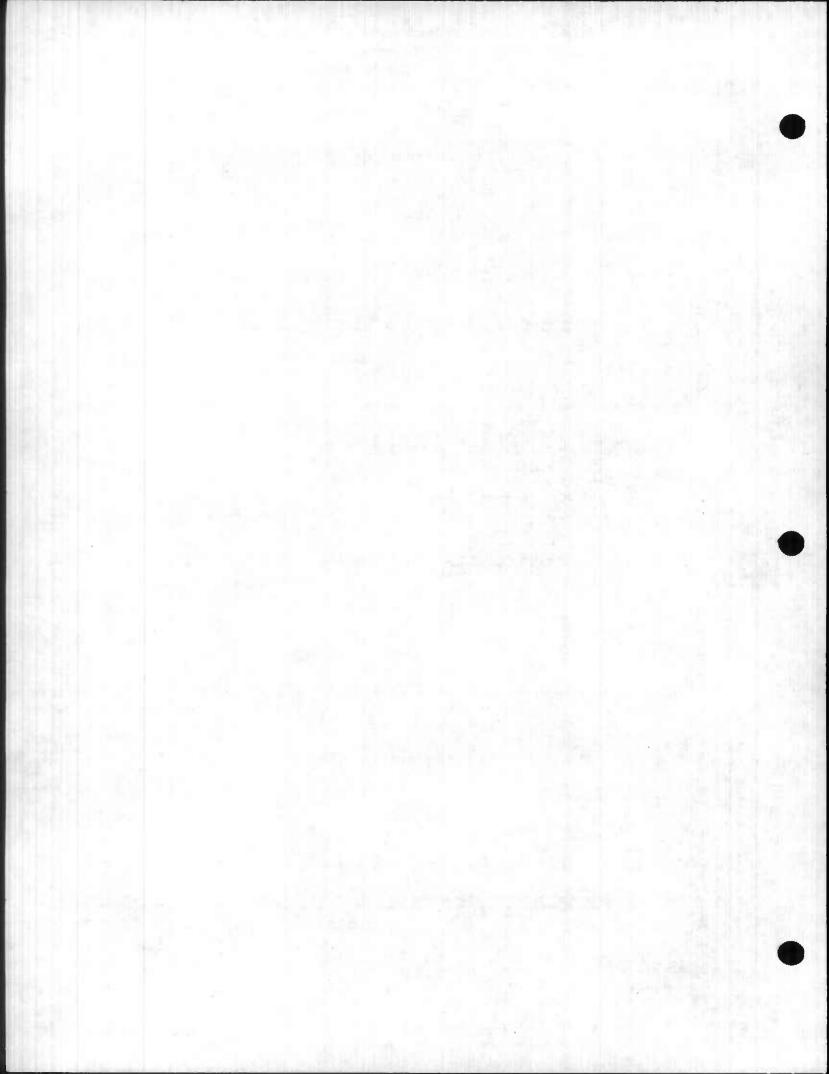
				e of Death		ng. No. 00 4	2624		
Physician	1. Decedent's Name (First, Middla, Las	0		Month	2. Date of Death  Month  Day  Year				
/Medical Examiner	4a Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	4c. County of Death	0031		
Examiner		Northwest Hospital		Rar	ndallstown		altimore		
Funeral	5. Social Security Number 6. Se	7. Age (In yrs.	last birthday) If Under	r 1 Year   If Under 24 Hrs	8. Date of Birth	8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Country)			
Director	219-40-9085	□ M 2□ F X	56 Yrs.				Baltimore, MD		
wo man	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location				10d. Insida City Limits		
Mary Franch	MD Ba	Iltimore		Baltimore			1 ☐ Yes 2 ☐ No		
with the Mar or 28s-fal be notified Director	10e. Street and Number	illimore i	10f. Zip		10	g. Citizen of What Co	untry?		
th wi	1401 Lafayette Ave.			21207		U.	S.A.		
r items 234	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	,S. 13. Was Dece If Yes, spe	dent of Hispanic Origin? (Scify Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White			
ified within 72 hours after death with the Maryland Hygiens. The trian 12 a or 28 a f ahow int, the Wedge Exeminer must be notified at the Completed by Funeral Director.	1 Nevar Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yas 2 ☐ No If Yes, Give X Year or Detes:	1□ Yes	2□No Specify:		Specify:	White		
n 72 hours "netural", d	15. Decedent's Ed	ucation	16a. Decedent's Usu	al Occupation	1	16b. Kind of Businass/I			
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the Hard	20a. Method of Disposition	ra Coady 20b. F	Place of Disposition (New	afayette Ave. Balt		207 20c. Location - City or 1	Town, State		
5 85 F P	1 Burial 2 Cremation 3 4 Opnation 5 Other (Specify	nemoval from State	emetery, cremetory or o		01/02/01	Sykacyilli	e, Maryland		
permit. Pa Departmen Important: any injury pnce.	21. Signature of Funeral Service Licens			lemorial Park and Address of Facility	01/02/01	Sykesviii	e, iviai yiailu		
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	Part1. Enter the diseasa, of comp shock, or heart failure. List only			le of dying, such as cardia	c or raspiratory arra	st,	Approximate Interval Between		
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	. Acute	n furior n	Myocardia	Infar	ction	Onset and Death		
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ficate be executed as the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	list conditions, g to immediate							
ificate be exa g physician a as the buriat-	cause. Enter Underlying Cause (Disease or Injury that initiated events	. Maneto	s ynulling	15		i			
= 0 =	resulting in death) Last	Dua to (o	r as a consequence of):						
death certing a attending of for use sician/M		d							
0 0 0 0	Part II. Other significant conditions co	ntributing to death but not rase	ulting in the underlying of	ause given in Part I.	23b. Did tol	bacco use contribute	to the cause of death?		
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n signed					24a. Was an	autopsy 24b. V	Vere autopsy findings		
The lew require					perform	C	vailable prior to completion of cause of death?		
The le					1□ Ye	s 2 100 1	Yes 2 No		
ysician: The lev s certificata has director, page 2 fo Be Comp	25. Was case referred to medical			26. Place of De	ath (Check only one				
Physician: this certific ral director, To Be	examiner? 1 Yes 2 No	Hospitel: 1 ☐ Inpatient 245	ER/Outpatient 3 DO	OA Other: 4 Nursing	Home 5 ☐ Reside	nce 8 Other (Spec	cify)		
tending Ph leeth. tor: After th the funeral	27. Menner of Death 1 ☑ Netural 5 ☐ Pending	28a. Dete of Injury (Month, Dey Year)		28c. Injury at Work?	28d. Describe ho	w injury occurred			
Attending tr deeth. ector: After by the fune iffication	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	M dem street factor	1 Yes 2 No	28f Location /Str	eet end Number or Ru	rel Route Number		
. वर्षेत्र हैं।	4 ☐ Homicide determined	building, etc. (Specify	y)	y, omos	City or Town		rei riodie ridiliber,		
To the Hospital or Aff within 24 hours after of To the Funeral Direct completaly filled in by Medical Certifi	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowner: On the basis of examinal	wledge, death occurred tion and/or investigation	at the time, date and place, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) end manner es ite and place, and due	steted. to the ceuse(s)		
within 2 To the comple	29b. Signature and title of certifier	and manner stated.	290	c. License number	29	d. Date signed (Month	n, Day, Year)		
F ≯ F 8	De queusto	Mus.	נו	1005 1339	-				
10	30. Nama and address of person who co	ompleted cause of death (Item	23a) (Type, Print)	1	U	KUUVIKI !	u, aco		
0	Dr. Lyung Herrian	1.5401 old	Court Rd.	lourdals four	c amn	1133 (NI	NHC)		
State	31. Date filed (Month, Dey, Year)	32. Registrar's Signa	ture y	7					

Annal James A

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State of Maryland / Department of Health and Mental Hygiene 142625

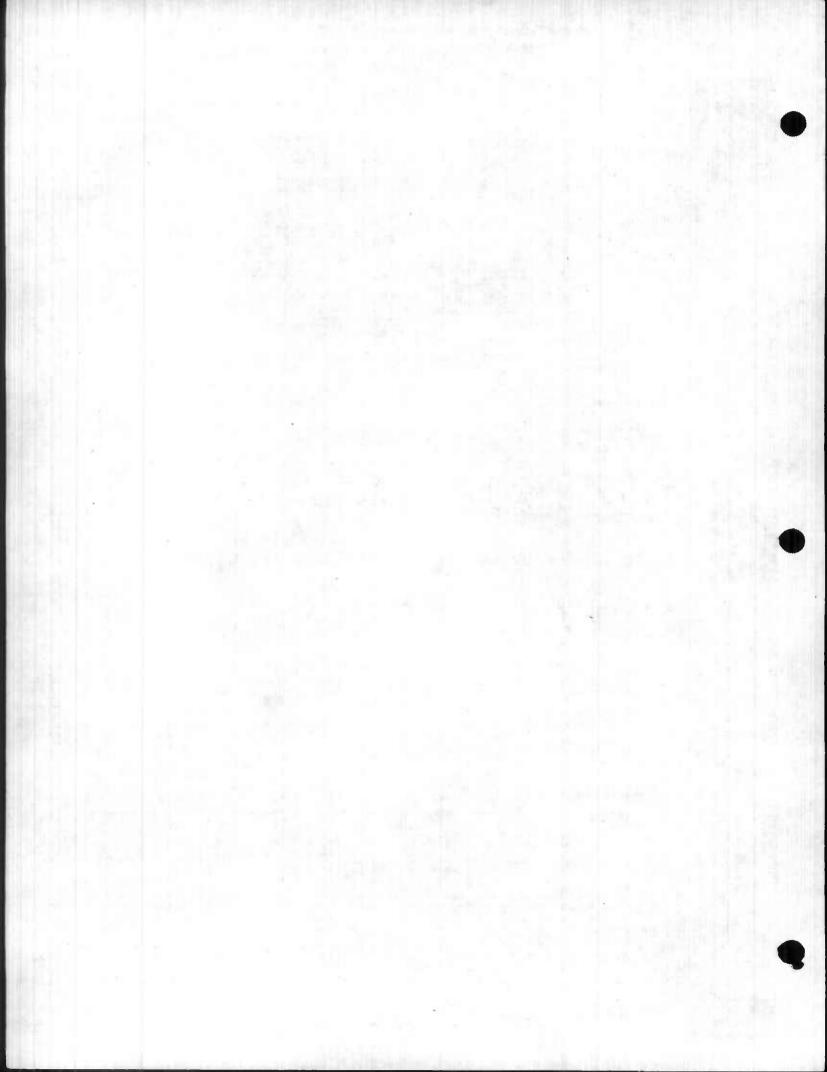
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Sequentially list conditions, if any, leading to immadiate causa. Entar Undarlying Causa (Disease or Injury that initiated evants rasulting in death) Last  b													
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	1 U Ir	1 Inpatient 2 EH/Outpetient 3 DOA 4 Nursing											
Neturel 5 Pendin	g (Month	h, Day Year)	Day Year) 28b. Time of Injury				28d. Describe now injury occurred						
Suicida 6 Could	and he				294 Location (Street and Number or Rural Route Number								
Homicida determ	buildin	28a. Placa of Injury - At home, farm, straet, factory, offica building, etc. (Specify)					City or To	281. Location (Street end Number or Rural Routa Number, City or Town, Stete)					
artifiar 1 Certifyin	g Physician: To the I	best of my kno	owledge, de	eth occurre	d et the tin	ne, dete end ple	ce, and due to tha	cause(s) and man	nar es s	tated.			
one) 2 Medical	examiner: On the ba	ar stated.	etion and/or	invastigatio	n, in my o	pinion, daatn oc	curred at tha time,	dete end piece, ai	na aue t	o the cause(s)			
ignature and titla of certifie	r			2				29d. Data signed	(Month,	Day, Year)			
Norm N	Muli- mo				D4	7683	701	1/2/01					
A MARKANA TANALA A	who complated cause	a of daath (ita	m 23a) (Tyr	e, Print)				1.					
ma and address of person					2								
3 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Iminar?   Yas 2   No   No   No   No     Accident   Suicida   Homicida     Acridiar   1   Certifying     Grant   No   No     Acridiar   1   Certifying     Grant   No     Grant   No   No     Grant   No	Hospital: 1   In   In   In   In   In   In   In	Mospital: 1   Inpatient 2     Yes 2   No	Mospital:     Inpatient   2   ER/Outper     Mospital:     Inpatient   2   ER/Outper     Meturel   5   Pending invastigation     Suicida   Gould not be determined     Homicida   28a. Dete of Injury   28b. Time     Accidant   28a. Placa of Injury - At homa, farm,     Building, etc. (Specify)     Medical Examiner: On the basis of axaminetion and/or and mannar stated.   Mospital:   Inpatient   2   ER/Outper     Mospital:   Inpatient   Inpatient     Mospital:   Inpatient   Inp	Money of Death   Money of Death   Money of Death   Meturel   5   Pending invastigation   28a. Placa of Injury   28b. Time of Injury   Month, Day Year   28b. Time of Injury   Month, Day Year   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa of Injury - At homa, farm, straet, factor building, etc. (Specify)   28c. Placa o	Mospital:     Impatient   2   ER/Outpetient   3   DOA   Other	Mospital:     Inpatient   2   ER/Outpetient   3   DA   Other:   A   Nursing	Is case rafarred to medical printing invastigation artiflar theck only and mannar stated.    Sease rafarred to medical printing invastigation in many of the printing invastigation and mannar stated.    Sease rafarred to medical printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing in printing invastigation invastigation in printing invastigation invastigation in printing invastigation in printing invastigation in printing invastigation in printing invastigation in printing i	In yes 2 1 No  Is case rafarred to medical minar?  I hospital: 1 Inpatient 2 EP/Outpetient 3 DOA  Other: A Nursing Home 5 Rasidence 6 Other North Neturel invastigation  Accident Injury Manuscida invastigation  Suicida Homicida  I Could not be determined  28a. Placa of Injury - At homa, farm, straet, factory, offica  28a. Placa of Injury - At homa, farm, straet, factory, offica  28b. Location (Street end Number City or Town, Stete)  28c. Injury Manuscida  1 Yes 2 North Nursing Home 5 Rasidence 6 Other North Nursing Home 5 Rasidence 6 Other North N	performed?    Second   Continue			



State Registrar JAN 0 8 2001

32. Registrar's Signature

& Sparks



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day PATRICIA RUTT WOLF 7:43 AM DECEMBER 29 2000 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/
If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Oct. 29, 1948 Good Samaritan 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Months Days 1□M 2KDF 215-52-0762 52 Md. Usual Residence of Decedent 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits Dundalk Md. 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6916 Fait Ave. 21224 USA 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No it Yes, Give Year or Dates: 14. Raca - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried Specify White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housewife Home 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Robert W. Bogert Doris Kuhl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6916 Fait Ave. Carl Wolf husband Balto. Md. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Jan. 3 Oak Lawn Cem. Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 2001 21. Signature of Fuperal Segues Lipensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, stopp, or heart failure. List only one cause of each line. Approximate Interval Between Onset end Death Immediete Cause (Final disease or condition resulting in death) SEPSIS PERMACATHETER Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown DISEASE, PERIPHENAL RENAL 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an eutopsy performed? ACUTE MYOCAR DIAL INFARCTION 1 Yes 2 No 1 ☐ Yes 2 ☑ No DISTASE 26. Place of Death (Check only one)

Physician /Medical Examiner

physician the burial

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page

certificate

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filled in by

Vital

Division Attending

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To the Hospital o within 24 hours af To the Funeral DI

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Completed

Certification: To Be

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**Funeral** 

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should be Mertal marked

Pages 1 and 2 s nent of Health an ant: If them 27 fs 1

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. VASCULAR DISEASE, SORONARY ARTORY

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 5 Pending Investigation

28a. Date of Injury (Month, Day Year) 6 Could not be determined

28c. Injury at Work?

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

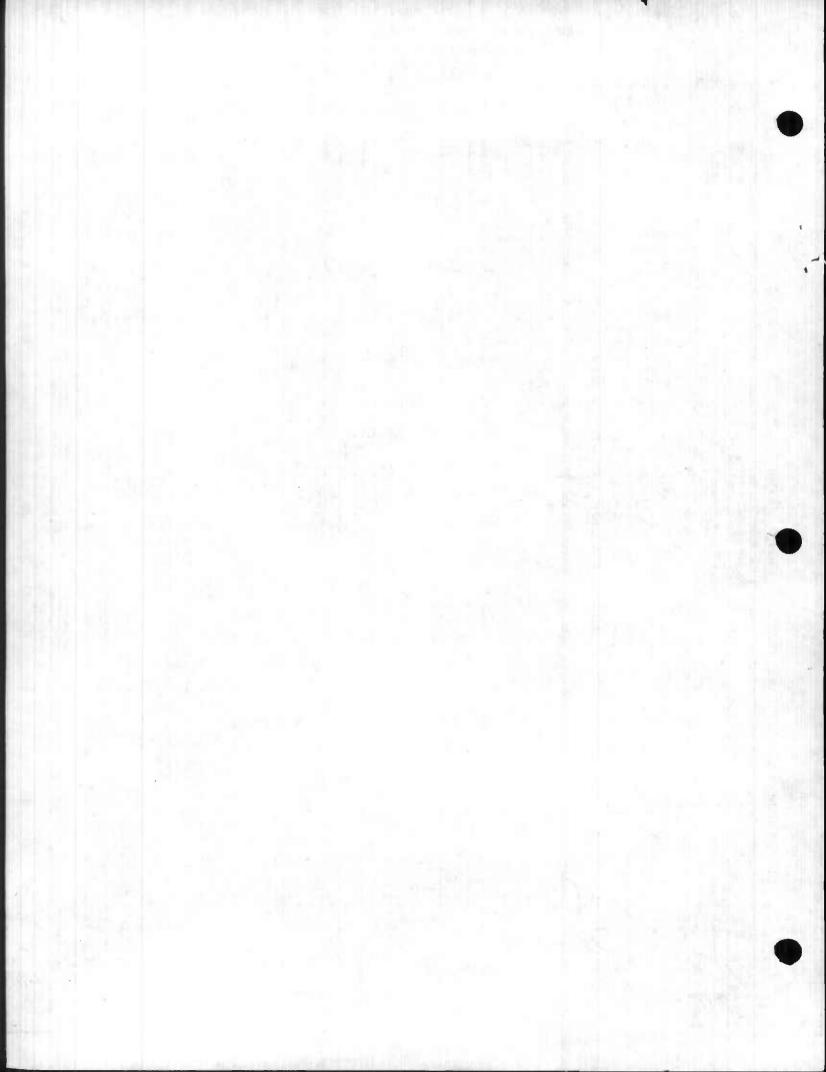
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOLH NAVEN BOULEVAND 21239

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

NGUYEN

GOOD SAMARITAN MOSPITAL 32. Registrar's Signature

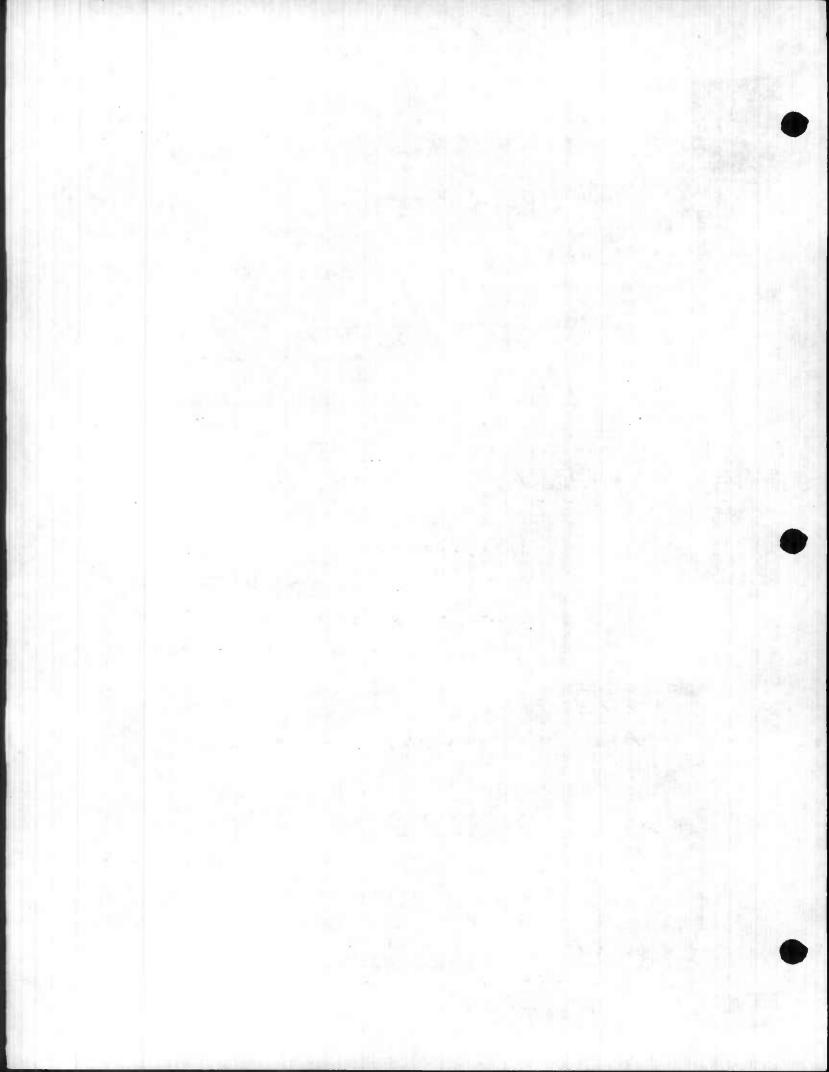
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 2 6 2 8

				Certificate o	f Death	Re	eg. No.					
	Dhualaian	1. Decedent's Name (First, Middle, La				2. Date of Death	h	3. Time of Death				
	Physician /Medical	DORIS		ABELL		December						
	Examiner	4a Facility Name (If not Institution, gir Southern Maryla	· · · · · · · · · · · · · · · · · · ·		4b. City, Town, or L Clinton		Prince G					
	Funeral Director		Sex 7. Age (In yrs. 10 M 21) F 76	last birthday) If Under 1 Yea  Yrs. Months Day		8. Date of Birth (Month, Day NOV . 30	9. B 1924 Was	irthplace (State or Foreign Country) . D. C.				
65.3	Du .	Usual Residence of Decedent  10a. State 10b. County	10c Ci	ry, Town or Location				10d. Inside City Limits				
	e Menyle		arles	Waldorf				1 ☐ Yes 2 💢 No				
	fier death with the Menjand frems 23s or 28s-f show ther must be notified at Funeral Director	10e. Street and Number 2747 Sun Valley	Drive	10f. Zip Code	20603	10	0g. Citizen of What 0	country?				
	5 22 5	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	,S. 13. Was Decedent of If Yes, specify Ci	f Hispanic Origin? (Spuban, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, nite, etc. nite				
	ind 21215-0 be filed within 72 ho tal Hygiene. d other than 'natural avant, fre Healdell Be Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		16a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti Secretary	ne during most of work	ting	16b. Kind of Busines J. S. Gove Department	rnment				
16:14	re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours eft theelth and Mental Hygiene. then 27 is marked other than "natural", or other traumatic avent, the healtest Energy	17. Father's Name (First, Middle, Last David Alvin Bro		1 0001 0001 3	18. Mother's Nam		Maiden Sumame)	<u> </u>				
9	ary shou and M a mark	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Stre	et and Number or Ru	ral Route Number	, City or Town, State	, Zip Code)				
(3)	Part P	Richard M. Abell		2747 Sun Val								
red	Pege Pege nent o int: If	20a. Method of Disposition  1 Dentation 5 Other (Speci	JHemoval from State	Placa of Disposition (Name of cemetery, crematory or other p yland Veterans			20c. Location - City of 1 Cheltenh					
Expired @	Balt Permit. Depart Importu	21. Signature of Funeral Service Lica JOHN P. KNIS	The Huntt Funeral Home, Inc. p.O. Box 156, Waldorf, Maryland 20604									
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	Approximate Interval Between Onset and Death									
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	ADENO CA	ARCINUMA	OF	LUN	6					
	Sit ad			or as a consequence of):	ver 1	1ETAS	CASES					
OK, Jumani	68760, ifficate be executed g physician and as the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	CACHE	or as a consequence of):	DIN	ANI	TIOI					
Jak Jan	- 0 0	that initiated events resulting in death) Last	d. HYPOZ	or as a consequence of):	,		COPE					
	death cert death cert e attendin e d for use	Dad II Other elgoideant conditions	postellution to don't but not on	usting In the underlying source	sives in Red I	22h Did to	phases use contribu	Ita to the cause of death?				
611	Is, P.O. Box es that the death cer igned by the attendir be detached for use by PhysicianA	Part II. Other significant conditions of	PIBRIL	CATIO	W	1 🗆 Y		Probably 4 Unknown				
16/66#	cord require been s should	MACNUT	RITION	AND DEF	+XPKATIO	24a. Was a perform		b. Were autopsy findings available prior to completion of cause of death?				
#	Vital Relationary The law certificate has rector, page 2 Be Comp	Destrict State of				1 🗆 Ye	es ala No	1 ☐ Yes 2 ☐ No				
	f Vital Raysten: The I sis certificate had director, page	25. Was case referred to medical axaminer?	Hospital:			th (Check only on	ne)					
3	Physic this control direction of 1	1 Yes 20 No.	1 Inpatient 2	ER/Outpatient 3L DUA	Other: 4 Nursing H		enca 6 Other (S) ow injury occurred	pecify)				
0	ding ding th.	1 Natural 5 Pending Investigation	(Month, Day Year)	Injury V	Vork? ☐ Yes 2 ☐ No	200. 2000.00 11	on injury december					
Hell, Doris	Division of within 24 hours than ding Ph within 24 hours state death completely filled in by the funeral Medical Certification:	3 Sucide 6 Could not be determined	28e. Placa of Injury - AI h building, etc. (Specia	ome, farm, street, factory, offic fy)	00	28f. Location (SI City or Town	treet and Number or n, State)	Rural Route Number,				
He,	To the Hospital within 24 hours of To the Funeral completely filled		hysician: To the best of my kno miner: On the basis of examina and manner stated.									
A	To the within 7 To the comple	29b. Signature and title of certifier	& Leo	MD 290. Lice	1578	9 2	29d. Date signed (Md	onth, Day, Year)				
		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print) D.	ANILO	-087	LEE,	M. D.				
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signi	/		1	LYCA	ND NULL				



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** December 2000 Henry Armstrong /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Unctar 1 Yaar | If Under 24 Hrs. | 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Hours 10 M 20 F Months Yrs. Director Aug. 2, 1923 215-14-1439 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Y☐Yes 2☐No Washington Hagerstown Herns 25a or 25a-Iner must be notifi 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Din 10911 Decker Ave. 21740 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedenf Ever in U.S. Was Decedent Armed Forces? %☐Yes 2☐No 1943 frYes, Giva 1946 Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Private Industry 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 8 Pages 1 and 2 should be ment of Health and Menta sent: If Item 27 is marked Jacob Armstrong Daisy Irene Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madeline M. Armstrong / spouse 10911 Decker Ave. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation \$ □ Other (Specify) Rest Haven Cemetery 12/22/00 Hagerstown, MD 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742 239 Part). Enter the disease, or complications that caused the death. Do not enfar the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one datase on each line. Approximate Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Cardiac arrest Examiner Examine physicien end the buriel-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): neumoud Physician/Medical Due to (or as a consequence of): for use es Part II. Other algnificant conditions contributing to death but not resulting in the upderlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown renal Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy has is cartificate ha 1 Yes 2 No 1 ☐ Yas 2 ☐ No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 this 27. Manner of Death 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturat 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò To the Hospital
Within 24 hours a
To the Funeral Completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. (Check only one) 29c. License number 0 20 233 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier Pulivanti, MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BAPURAO PULIVARTI, M) 12931 Oak Will Ave, Hagerston, M21742 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 16 Rev 6/95

Armstrons

ames

ORIGINAL

NAME: ARMSTRONG, JAMES HENRY 08/02/1923 77 / M YU

YU,YANPING

H005055

DOS: 12/11/2000

H3042453245

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State of Maryland / Department of Health and Mental Hygiene 0 0 4 2630

			Ce	rtificate	of L	Death		Reg. No.							
	1. Decedent'a Neme (First, Middle, Las	ot)		2. Date of Death 3. Time of E											
Physician	Ruth Elizabeth AL	EXANDER	Month Day Year December 21, 2000 3:												
/Medical	4a Facility Name (If not institution, give		b. City, Town, o	or Location of De		y of Death	3:00 a.n								
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	5. Social Security Number 6. S	-	rs. last birthday	If Undar 1	Vaar	If Undar 24 H		Direth		Ington					
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or 28a-f or 28a-f or Director	Maryland Washing	ton	Hagers					1 011		Λ					
ath with the Marylan 123a or 28a-f show that be rectived at real Director	10e. Street and Number			10f. Zip C	000			10g. Citizan of	what Cour	ntry?					
ra 123	12 South Walnut S	treet, Apt.	515		217	740		U.S.A.							
ifter death v r frems 23 free man	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13.	Was Deceder	nt of His y Cubar	spanic Origin? n, Maxican, Pur	(Specify Yas or I		ce - Americ						
P. F.	1 Never Married 2 Married	1 ☐ Yes 2 🕅 No If Yes, Give		1 ☐ Yes 20	VI No	Specify:	Speci								
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	(Specify only highest gra-	College (1-4or 5+)	life.	DO NOT use	retired)	uning most of w	OIKHIY								
	0-8	0	Asse	mbly L	ine		Leather Company								
	17. Father's Neme (First, Middla, Last)					18. Mother's N	ame (First, Midd	le, Maidan Suma							
	Wilford M. Swope					Charl	otte Pad	lan							
marke marke	19a. Informant's Name/Relationship (7	Type, Print)	19b. Meil	ing Address (	Street e			ber, City or Town	. State. Zip	Code)					
475	Jerry Wolf - Son			Box 1				ennsylva							
- 주도등	20e. Mathod of Disposition	201	. Place of Disp			Shauy	Date	20c. Location							
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permit. Paga Departmant of Important: If it any injury or once.	4 Donetion 5 Other (Specify	□Donetion 5 □Other (Specify) Hagerstown Crematory								12/22/00 Hagerstown, Marylan					
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	examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpetie	at 20 004	Othe			sidenca 6 🗆 O	has /Cons	60					
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	3 Suicide 6 Could not be determined			n (Street end Nun Fown, Stete)	nber or Run	al Route Number,									
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within 2 compla	29b. Signature end title of certifier	,		29c.	License	number		29d. Date sign	ed (Month,	Day, Year)					
	Macer E. Ul.	men of).			07	3815		17/	22/	20					
	30 Nama and address of person who	completed cause of death (I	tam 23a) (Tuno	Print)		- 01		1	/						
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	Mary & Money 31. Date filed (Month, Day, Year)	32. Registar's Signature	majure	11/6	PCI	Le , ov	ryers	10001	un	11/1/					
State Registrar	DEC 2 6	2000	1	O F	OCZ	1500	1								



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dec. 18, **Physician** Ruth Betson 2000 7:15 p.m. Virginia /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Avalon Manor Nursing Home Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 27, 1922 9. Birthplaca (Stete or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2□ ₹ 236 28 5421 78 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23s or 28s-f show ther must be notified at Morgan Paw Paw 1 Yes 2 No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 25434 U.S.A. Route 1, Box 14 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 14. Race - American Indian, Black, White, etc. 11. Maritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "naturel", or item the Medical Examiner filed within 72 hours after Never Merried 2 Merried Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. Homemaker Own home permit Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If item 27 te marked other any Injury or other treumatic event 17. Felher's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Wilt Samue1 Gladys 01a Harvey Betson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) Route 1, Box 14, Paw Paw, WV 25434 Betty J. Betson 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1)XBurial 2 ☐ Cremetion 3 ☐ Removel from Stete Camp Hill Cemetery 12/22/2000 Paw Paw, WV 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligaria 22 Name and Address of Fecility Helsley-Johnson Funeral Home, Inc. 306 Union St., Berkeley Springs, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **₽**hysician Immediate Ceuse (Final diseese or condition resulting in deeth) /Medical Preumanic اطمى Examiner Due to (or es a consequence of): Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): USB BS Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hinknown Records. Be Completed by 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 ☐ Yes 2 ☐ NO 1 Yes 2 No of Vital Hospital or Attending Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Wursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To After this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Haturel 5 Pending investigation death. 1 Yes 2 No 2 Accident after death 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) 29a. Certifier Medical within 2 and menner steted. To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) - COLUMD DEC 19, 2000 D18019

State Registrar

DHMH 16 Rev 6/95

0

334 Mill Street, Hagerstown, MD 21740

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

Datta, Vasant

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## Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 42632

								Certifica	ate of	Death	F	leg. No.	0	76.001.		
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	Physicia /Medic	_	EVELYN TE	EVA	BELT						DECEMBI	ER 24 20	000	11:52 P		
	Examin	_	4a Facility Nama (If not in	stitution, giv	a street and nu	ımber)				4b. City, Town, or	Location of Death	4c. County	of Death			
		п	WASHINGTON C	OUNTY	HOSPIT	CAL				HAGE	RSTOWN	1	WASHI	NGTON		
	Funeral		5. Social Security Number	6. 5	Sex I□M 2⊠F	7. Age (In )		Month	der 1 Yaar	If Under 24 Hr Hours Mir		Year)	9. Birthpl	lace (Stata or Foreig		
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<u>y</u>	0284 4	2	HARRY CLAY	STULT	Z					MINNIE	ANNIE CAMPBELL					
lar			19a. Informant's Name/Relationship (Type, Print)					11111			Rural Routa Numbe					
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É	d in d	2	4 Homicide	/	build	ling, etc. (Spe	ecity)				City or Tow	n, Stata)				
	To the Nospital or Attanding Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	la C	29a. Certifier 1⊠ C	ertifying Ph	ysician: To the	a best of my I	knowledge,	death occurre	ed at the ti	me, date and place	ce, and dua to the d	ause(s) and ma	anner as si	ated.		
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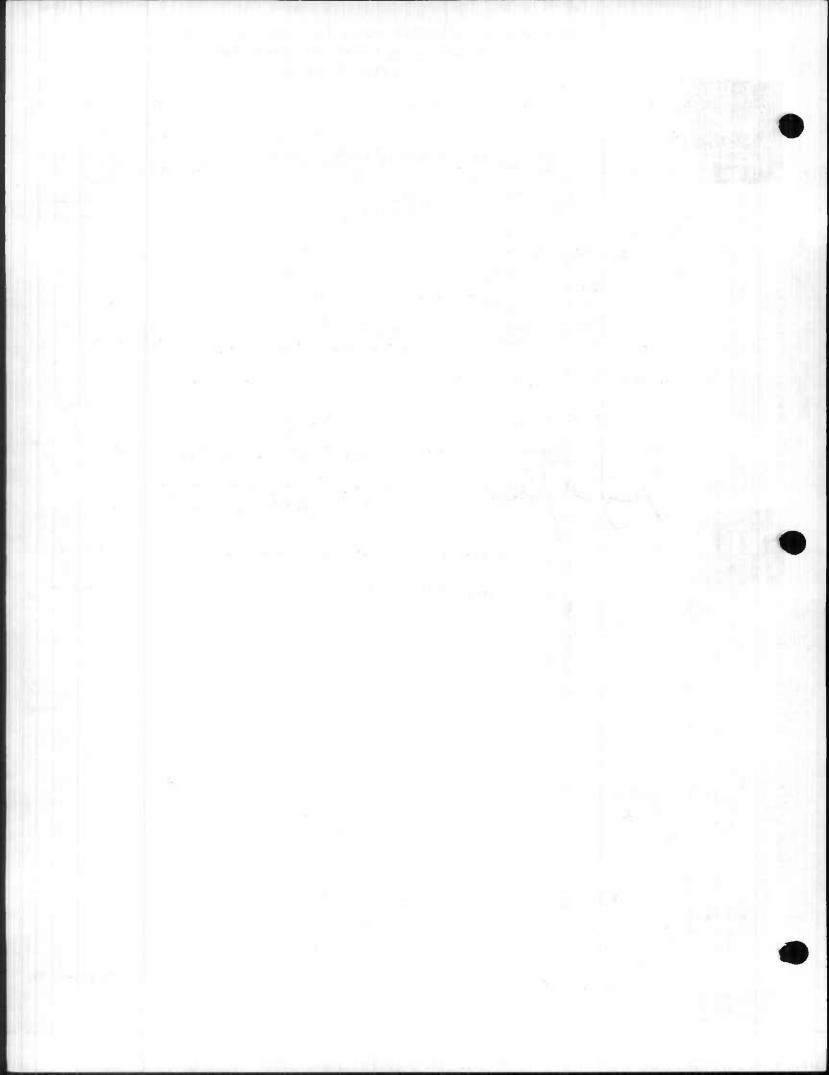
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 1 2 6

				C	ertificate of	Death		Reg. No	0.		
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Funeral Director		214-48-3474	Sex 7. Ag 1 Mg 2 □ F	6 (In yrs. last birthda 52 Yrs.	Months Devs		Min. 8. Date (Mont	of Birth th, Day, Year 20,	194	9. Birthple Counti	ce (Stete or Foreig ) Id.
Marylend a-f show	tor	Usuel Residence of Decedent	ERICK	10c. City, Town or	Location EDERICK					10	d. Inside City Limit:
h with the 23a or 28	al Director	10e. Street end Number 150 WEST ALL	SAINTS S	т.	10f. Zip Code	21701		10g. Ci	y?		
72 hours after death with the Maryland natural', or items 23a or 28a-f show Stat Evandret must be notilised at	by Funeral	11. Marital Stetus  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces?  1  Yes 2 If Yes, Give Yeer or Detes:	Ever in U,S. 1 1968-70	3. Was Decedent of If Yes, specify Cul		In? (Specify Yes Puerto Rican, et	or No- c.)	Blec	ce - American Indien, eck, White, etc.	
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permit. Pag Depertment Important: I any Injury o		21. Signature of Funeral Service Lice	ollus		22. Name end Addr GARY L. 110 WEST	ROLLÍ	NS FUN				0.1
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DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Physician Lauren Roberts Bagley, Jr. 9 2000 7:55 a.m. December /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 6. Sex 1 ₩ 2 □ F If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 19, 1931 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Deys Hours Yrs. 073-26-6031 69 Director Maine Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the M. Department of Heath and Mental Hygiens. Important: if Item 27 is marked other than "natural", or froms 23s or 28s-f any injury or other traumetic event, the Medical Examinar must be notified Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 907 Young Place 21702 United States Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Detes: 50-53 1 ☐ Never Married 2 [X Merried 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 biological lab technician federal government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 86 Lauren R. Bagley 2 Helen M. Bartlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) June L. Bagley / wife 907 Young Place, Frederick, MD 21702 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 12/11/00 Hagerstown, MD 22. Name end Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee gaequelino L. Kret 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) . Asterioschenotic Cardiovoscular Disease /Medical /ears Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Kespinatory Interfer þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 월 DOA 27. Manner of Death 28h Time of 28d. Describe how injury occurred

physicien and s the burlal-transit Box 68760 d for use as t ed by the e Records, P.O. signed by to Division of Vital al or Attending Physis effector: Attentia o funeral c Certification: 3 To the Hospital o within 24 hours of To the Funeral Di completaly filled in

Maryland 21215-0020

Baltimore,

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 🗷 Natural 1 TYes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

edical

Andrew Zarick, 31. Date filed (Month, Des. Feer) 2000 Segura Signeture 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

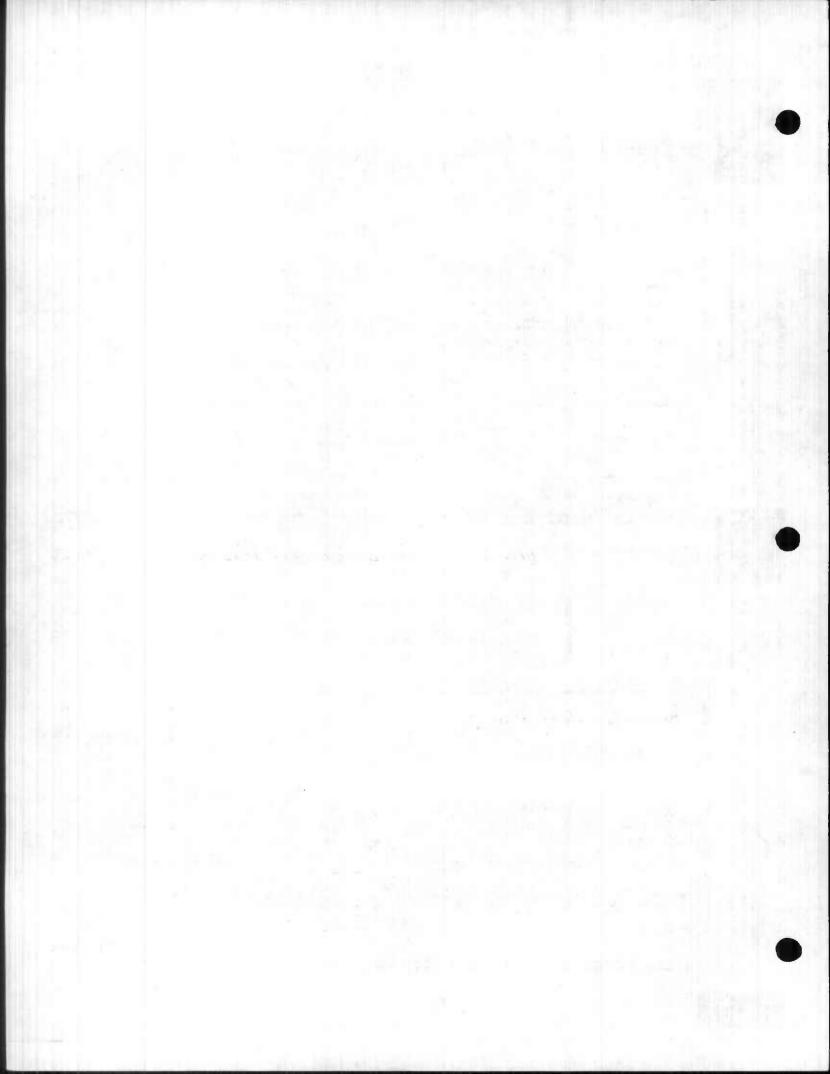
Jr

M.D.

1080 West Patrick St, Frederick, MD 21703

D35164

Ceenber 09, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Vear Month Leora Elizabeth Bannon December 10, 2000 attor of Deeth 4c. County of Death 6:22 a.m. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Frederick Frederick Frederick Memorial Hospital If Under 24 Hrs. 8. Date of Birth Month Dey, Year, Mar 21, 1920 5. Social Security Number If Under 1 Yeer 9. Birthplaca (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Deys Months Hours 1□M 2X F Pennsylvania 80 202-05-9934 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County Frederick Frederick Maryland | 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21704 12. Wes Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes 2X☐ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. White 1 Yes 2X No Specify: 16e. Decedent's Usual Occupation (Give kind of work done duning most of working life. DO NOT use retired) 16b. Kind of Business/Industry Federal Government

Director 10e. Street and Number 8202 Pembrook Court Funeral 1 Never Married 2 X Merried py 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Communications Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Lawley Helen R Laudensleager Daniel C 19a. fntormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8331 Old National Pike, Boonsboro, Maryland 21713 Mr. Greg Bannon / Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 IX Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Olivet Cemetery Dec 13, 2000 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Service Licenses M00706 Kobersen 106 East Church St, Frederick, Maryland 21701 ettl

23a. Parti. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart railure. List only one cause on each line.

Physician /Medical Examiner

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To the Hospital of within 24 hours a To the Funeral D

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Box

P.0.

Division of Vital Records.

Physician

/Medical

Examiner

10a. State

**Funeral** 

Director

7 is marked other than "natural", or itema 23a or 28a-f show treumatic event, the Mod cal Examinar must be notified as

filed within 7 Hygiena.

2 should be for end Mentel H

permit. Peges 1 and 2 should be f Depertment of Health and Mentel I Important: If Item 27 is marked ot any Injury or other treumatic even

Baltimore, Maryland 21215-0020

Examine Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last

Immediate Cause (Finel disease or condition resulting in deeth)

Onset and Death MYOCARDIAL Due to (or as a consequence of) MRTERIU SCIEROTIC CARDIU JASCULAR DISEASE UNKNOWN Due to (or as a consequence ot)

Physician/Medical Part It. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ARCINOMA OF TITE LUNG p 24b. Were autopsy tindings aveilable prior to completion of cause ot death? Completed 24a. Was en eutopsy DIAGETES performed? 1□ Yes 2 No 1 Yes 2 No 25. Was case reterred to medicef examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 🗷 ÉR/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Neturat 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, term, street, tactory, office building, etc. (Specify) 4 Homicide

29e. Certifier

GEORGE

VICE-PRE

15 Certifying Phyetcian: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) end manner es steled.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

1. Sheris

29c. License number D10587

29d. Date signed (Month, Day, Year)

Approximate Interval Between

1.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Migro Reac Host-

Registrar

31. Date filed (Month, Day, Year)
DEC 1 32. Registrar's Signeture 1 2 2000 Genera

HED. AFFAIN

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician
/Medical Examiner
Examine

**Funeral** Director

the Maryland r than "natural", or items 23e or 28e-f ahow the Macinal Examiner must be notified at 72 hours after death with filed within 7 Hygiene. permit. Peges 1 and 2 should be filed with Department of Health and Mental Hyglens Important: If item 27 is marked other the any injury or other traumetic event, that

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

physician end s the burial-transit The law requires that the death certificate be executed signed by the a has page 2 certificate Physician: this funeral After or Attanding To the Hospital or Attandin within 24 hours after death. To the Funeral Director: Af completely filled in by the fu death.

Box 68760

Division of Vital Records, P.O.

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 15, 2000 GLORIA MAE BRADY 1:48 P.M. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Frederick Memorial Hospital Frederick Frederick Hours Min. 8. Date of Birth (Month, Day, Year) 36 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1□M 2NF 64 214-34-9263 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits Maryland Frederick Frederick 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21701 U.S.A. 789 Wembly Drive, Apt B 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify à Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Educetion (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Certified Nusring Assistant Health Care 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Raymond Frye Edith Wetzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert J. Brady, Sr/Husband 789 Wembly Drive, AptB, Frederick, Maryland 21701 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 A Cremetion 3 ☐ Removat from Stete Resthaven Mem Gardens Dec 19, 2000 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 East Church Street, Frederick, MD 21701 oh of Funeral Service Lice Chesen MO0706 hplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death · SUBARACHNOTO / INTRACEREBRAL HEMORPHAGE Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION P 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was en eutopsy PNEUMONITA 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medice! examiner? 26. Place of Deeth (Check only one) Hospitat 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28h Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Netural 1 Tyes 2 No 2 ☐ Accident 6 ☐ Coutd not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

**DHMH 16 Rev 6/95** 

Maly 1.

31. Dete filed (Month, Day, Year)
DEC 1 8 2000 ▶ 32. Registrar's Signeture

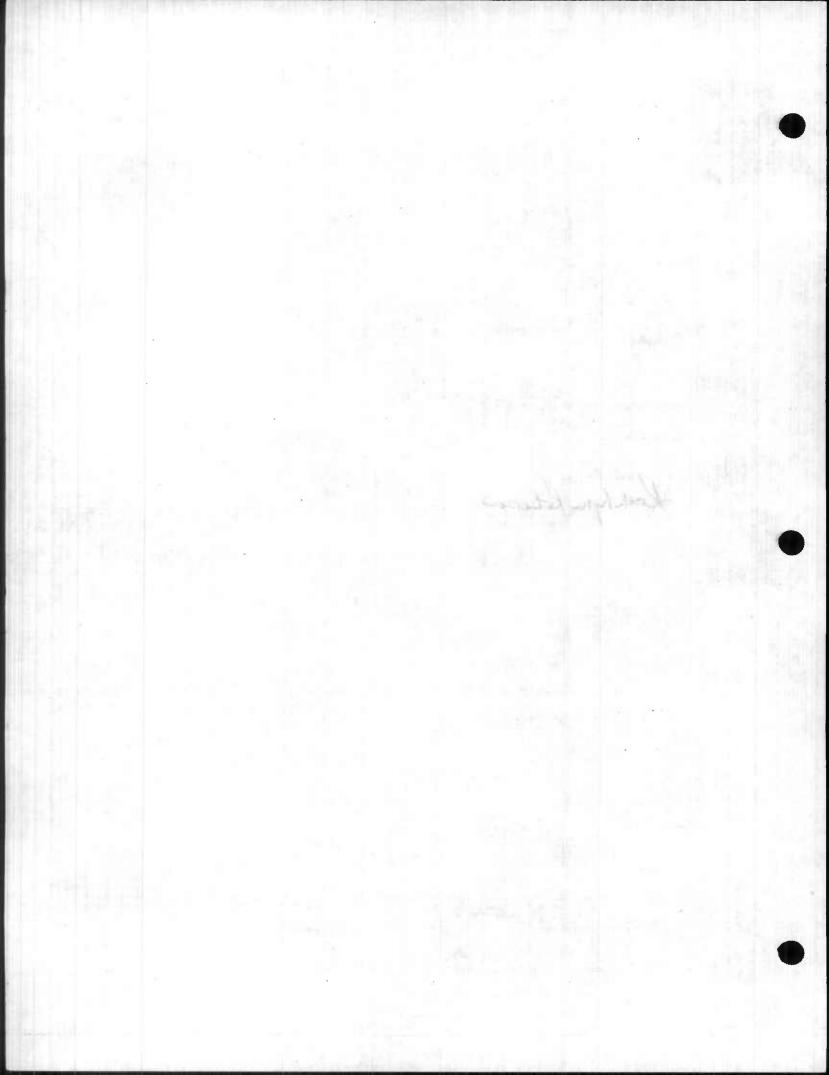
Mary P, Howell mo

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

books **ORIGINAL** 

Mary P. Howell, MD., 170 Thomas Johnson Drive, Suite 100, Frederick, MD 21702

046075



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 4 2 6 3 7

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/Medical Examiner	4a Facility Nema (If not institution, give street end number)  4b. City, Town,								wn, or Lo			County			
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Funeral				Age (In yrs. la	st birthdey)	If Unde		If Under	24 Hrs.	8. Data of B (Month, L	irth			lece (Stete or Foreigns)	
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Kerthy Loone 11 2FACA:

#### Please Type or Print in Black Indelibie ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Annie Mae Crossfield 10 m 25 ec 00 4b. City, Town, or Location of Death Hagerstown 4a Facility Nama (If not institution, give street and number) 4c County of Death Washington If Undar 24 Hrs. If Under 1 Yaar 8. Data of Birth (Month, Day, Year) Sept. 8 1940 9. Birthplaca (Steta or Foraign Country) New Jersey 5. Social Sacurity Number 7. Aga (In vrs. last birthday) Months Days 1□ M 2 F Hours 60 219 44 4331 Yrs. Usual Rasidance of Decedant 10d. Insida City Limits Was Myngton 10c. City, Town or Location Hagerstown 1 Yas 2 □ No 10g. Citizen of Whet Country? United States 10e. Street and Number 802 Woodland Way 10f. Zip Code 2 7 4 2 12. Was Dacadant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 Nevar Married 2 Married Specify: Black 1 ☐ Yas 2 ☒No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decadant's Education (Spacify only highast grade complated) Elementary/Secondary (0-12) College (1-4or 5+) Production Industrial 17 Father's Name (First, Middle, Last) Tabb Allen Watts 18. Mother's Name (First, Middla, Maiden Sumama) Annie Wheeler Watts 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) 802 Woodland Way Hagerstown, Maryland 21742 Thomas E. Watts/ Son 20a. Mathod of Disposition 20b. Place of Disposition (Ivalia of Cedaria), Indiana of Medicopk. Indiana (Ivalia) 20b. Placa of Disposition (Nama of 20c. Location - City or Town, Stata 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Hagerstown, Md. 4 ☐ Donation 5 ☐ Othar (Specify) atsons Funeral Hagerstown, Md. 21. Signatura of Funeral Sarvice Licensaa 22 Name and Addrass of Facility 15wener 23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one causa on each line. Approximata Intarval Batween Onset and Deeth Immadiata Causa (Final disaasa or condition resulting in death) 5 Years 60100 Cancer Dua to (or as a consaguanca of) Saquantially list conditions, if any, laading to immadiate causa. Entar Undarfying Cause (Disaase or Injury that initiated avants rasulting in daath) Last Dua to (or as a consaguança of): Dua to (or as a consequance of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yas 2 TNo 1 Yas 2 No 25. Was case referred to medical axaminar? 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Residance 6 ☐ Other (Specify) 1 Yes 2 No

**Physician** /Medical **Examiner** 

thet the death certificate be executed

Hospital or Attending Physician:

\$

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24 hours after death.

within 24 hours aftar das To the Funeral Director completaly filled in by th

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Directo

Funeral

by

Completed

Be

**Funeral** 

**Director** 

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mantel Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Examiner Physician/Medical by

physician and s the burial-transit 88 attending for use as signed by the a d be datached f pege 2 s has certificate l diractor. After this funeral

Certification:

Completed Be 2

Medical

4 Homicida 29a. Cartifiar

27. Menner of Death

1 Naturel

2 Accidant

3 Suicida

6 Could not be determined

28e. Dete of Injury (Month, Day Year) 5 Panding investigation

28b. Time of

28e. Pleca of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

28c. Injury et Work? 1 ☐ Yas 2 ☐ No

041667

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

28d. Describe how Injury occurred

1 🖸 Certifying Physician: To tha best of my knowledge, daeth occurrad at tha tima, data and placa, and dua to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at tha tima, date and plece, and dua to the cause(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licansa number

29d. Data signed (Month, Day, Year) 12.26.00

Mulon 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

Michael J. McCorneck Medical Compus Led. Desertour MO 2/742 11110

State Registrar 31. Data filad (Month, Day, Yaar) DEC 2 7 2000



Sec. 13030

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.,

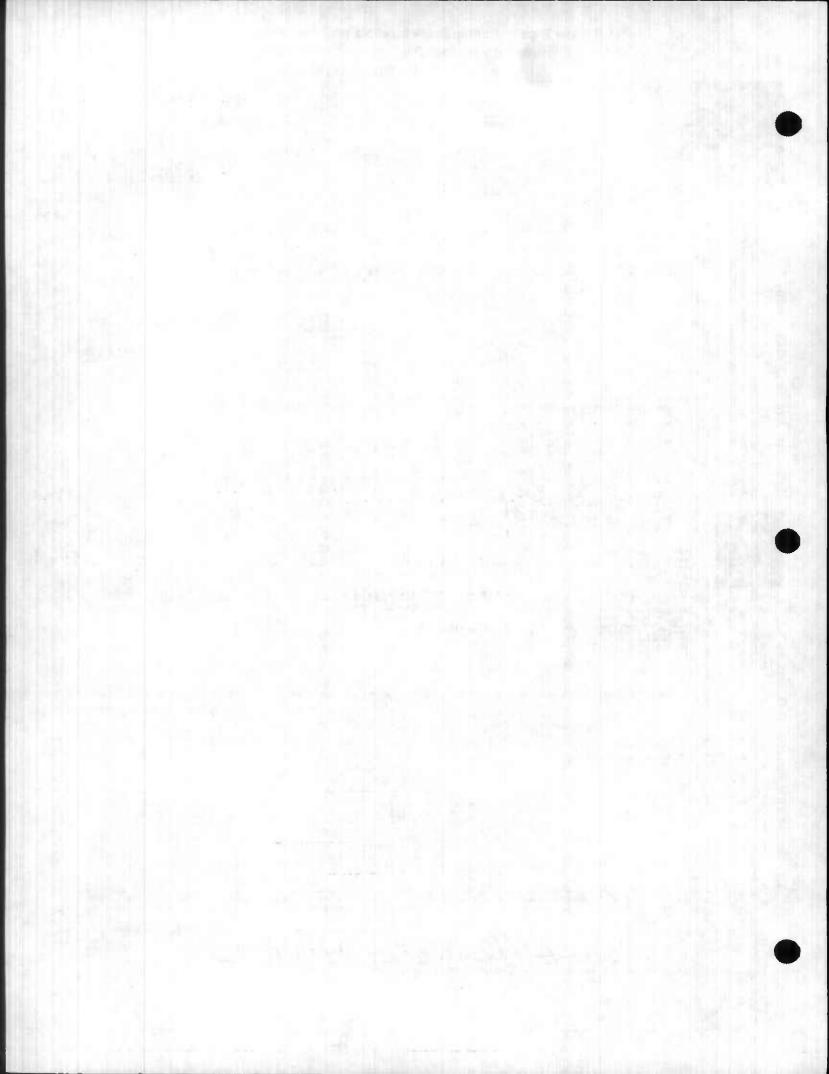
State of Maryland	/ Department	of Health and	<b>Mental</b>	Hygiene	j
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Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dele of Deeth December 08, 2000 Physician 9:35 AM James Bernard Creager, Sr. /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 6804 Amelano Drive If Under 24 Hrs. 5. Social Security Number If Under 1 Yeer 8. Dele of Birth (Month, Dey, Year)
July 26, 1923 Birthplece (Stete or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1XXM 20 F Months Deys Hours Yrs. 219-14-9373 Maryland Director Usual Residence of Decedent 10e State 10b. Count 10c. City. Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 Yes 2 No 28a-f Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? must be n 6804 Amelano 21702 Drive U.S.A. Items 23s Funeral 12. Wes Decedent Ever in U,S. Amed Forces? XXYes 2 □ No If Yes, Give 1943–1945 Yeer or Detest 943–1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 ò 1 Yes 2 No Specify. þ White 3D(Widowed 4 □ Divorced s filed within 72 hou I Hygiene. other than "neture vent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) Carpenter Construction permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 is merited other any Injury or other trainment. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be John Unknown Creager 19a. Intormant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Mr. James B. Creager, Jr., Son 5515 A Mountville Road, Adamstown, Md. 21710 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)

Mount Olivet Cemetery, Dec. 11, 2000 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel trom State Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney and Basford P.A. Funeral Home 21. Signature of Funeral Service Licensee MO0255 0 106 East Church St., Frederick, Maryland 21701 23a. Pert1. Enter the disease, or complications this caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause or each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediete Cause (Finel disease or condition resulting in deeth) 3 months Lung CANCER Examiner Due to (or as a consequence ot): Physician/Medical Examiner SPINAL METASTASIS Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last Due to (or as e consequence of): Preumonitis Box 68760. Due to (or es e consequence ot) 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 12 Yss 2 No 3 Probably 4 Unknown by of Vital Records, 24b. Were eutopsy tindings available prior to completion of cause of death? 24e. Wes an eutopsy performed? Be Completed 1 Yes 22 No 1 Yes 20 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 27. Manner of Deeth To the Hospital or Attending Pt within 24 hours after deseth.

To the Funeral Director: After the completely lilled in by the funeral 28c. Injury et Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the cause(s) and manner steted. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier December 8, 2000 assaras 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene B. Casagrande, M.D., 1564 Opossumtown Pike, Frederick, Md. 21702 31. Dete filed (Month, Day, Year) 32. Registra/s Signeture State DEC 1 1 2000 Registrar



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 2640

		Certificate of	Death	Reg	. No.	4204	10				
isia	Decedent's Nama (First, Middla, Last)			2. Date of Death Month		Yaar 3. Tin	na of Death				
nysician Medical	Bertram Jones Cleaves			December	18,20	00 10:3	30 a.m.				
kaminer	4a Facility Nama (If not institution, give street and number)		4b. City, Town, or Lo		4c. County of						
	Frederick Memorial Hospita	7 4444 4 444	Freder		Frede						
neral ector	031-03-1199 ¹₹M 2□F 83	Yrs. last birthday) If Under 1 Yea Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day y Sept. 17	(ear) 917	9. Birthplaca (St. Country)	us etts				
	Usual Rasidence of Decedent           10a, Stata         10b, County         10c.	City, Town or Location				10d. insid	de City Limits				
abel or	Md. Frederick	Frederic	k				Yas 20 No				
Le notified at Director	10e. Street and Number 5726 Jefferson Blud.	10f. Zip Coda 217		10g	10g. Citizan of What Country? U.S.A.						
xamine must by Funeral	11. Marital Status  1 Never Married 2 Married 12. Was Decedent Ever in Armed Forcas?  1 Never Married 2 Married 1 Never Married 2 No	13. Was Decedant of If Yas, specify Cu	Hispanic Origin? (Spe ban, Maxicen, Puerto I o Specify:	city Yas or No- Rican, etc.)	Black	- American India k, Whita, atc.	n,				
	15. Decedant'a Education	16a. Decedant's Usual Occ	upation	16	ib. Kind of Bu	sinass/Industry					
t, the Medical Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Giva kind of work don lifa. DO NOT usa ratir	a duning most of workingd)								
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avent Be (	17. Fathar's Nama (First, Middla, Last)		18. Mothar's Nama		idan Sumame	a)					
To To	Lucius W. Cleaves		Vaisy	M. Jones							
rentus	19a. Informant's Name/Ralationship (Type, Print)	et and Number or Rura									
Par .	Jill A. Cleaves (Wife)	5726 Jeffers									
ury or of		b. Place of Disposition (Nama of cemetary, crematory or other pi miths burg Crema		ec. 20.		city or Town, Stat bwrg, Md.					
any inj	21 Signature of Funeral Service Licensee	22. Nama and Add Davis Fun	Att at I House	12525 Bru Smithsbu							
	23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one ceuse on each line.	eath. Do not enter the mode of dy				Approx	rimata Il Between				
cian						Onset	and Death				
dical iner	Immediata Cause (Final disease or condition	MYOCARDIA	+- INFI	ARCTION		35	- min.				
	Immediata Cause (Final disease or condition rasulting in death)  a. ACUTE MYOCARDIA - INFARCTION 35 min  Due to (or as a consequence of):  b. ARTERIO SCLEROTIC CARDIO VASCULAN DISEASE UNKNOWN										
lal-transit Examiner											
Xan	Sequentially list conditions, if any, leading to immediate	Dua to (or as a consequence of):									
	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events					i					
as the burial-transit ledical Examir	resulting in death) Last	o (or as a consequence of):									
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rector, page 2.				1 ☐ Yas	2 🕅 No	1 🗆 Yas	2□ No				
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director,	axaminar?	ER/Outpatient 3 DOA	26. Place of Death	na 5 ☐ Rasidan		e (Cancibe)					
70	27. Mannar of Death 28a. Data of Injury	28b. Time of 28c. Inj	jury at	28d. Dascribe how							
tion:	1 ☑Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation		ork? □ Yas 2 □ No								
in by the	2□ Cuiside 6□ Could not be	t home, farm, street, factory, office	9	28f. Location (Stre City or Town,	et and Numbe Stata)	er or Rural Route	Number,				
completely filled in by the funeral Medical Certification:	29a. Cartifier (Check only one)  1 Certifying Physician: To the best of my leading to the basis of example one)  1 Medical Examiner: On the basis of example one of the basis of the basis o	knowledga, daath occurred at tha ination and/or invastigation, in my	tima, data and place, a opinion, daath occurre	and due to the cou ed at the time, date	sa(s) and ma a and place, a	nnar as stated. and dua to tha ca	use(s)				
Me	29b. Signatura and titla of certifiar	29c. Lica	nsa number	290	d. Data signed	i (Month, Day, Ye	par)				
Ö	1 C- A 1-	11Ph D1	0587	1	2/20	12000					
	20 Name and address of more to any 1.	0 / / / / /		Deserve	Lich	NIA- IT	288				
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Chal			1171719	F/COVEC	, ,	70 4	10)				
Pew State	29b. Signatura and titla of certifier  29b. Signatura and titla of certifier  30. Nama and addrass in person who completed ceusa of daath (I	29c. Lica 29c. Lica D 1 Itam 23a) (Type, Print) CE - PREJ. MED 1	nsa number 0587		Data signed						

DUMBUL 46 Day 6005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Departme	nt of Health and Mental Hygiene
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Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** 26, 2000 2:55AM Odessa Evelyn Dewitt December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Garrett County Memorial Hospital Oakland Garrett 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 F Yrs. Director 214-36-6241 89 Nov. 29, 1911 Sang Run, MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland McHenry Garrett 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 5089 Sang Run Road 21541 Funeral USA filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 Yes 2X No Specify: White Specify: by 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) t6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Hygie other i 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Peges 1 and 2 should be fill ment of Health and Mentel H lant: If item 27 is marked off Elijah Fuller Frantz Martha Ann Hoff 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha E. Davis, Daughter 93 Fratz Road, Accident, MD Baltimore, other 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges Department of Important: If it any injury or of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hoyes U. Methodist Cem, Dec 28,2000 Friendsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Newman Funeral Homes, P.A., 179 Miller Street me P.O. Box 275, Grantsville, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or need feiture. List only one cause on each line. Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical respiratory failure 12 hours Examiner Due to (or as a consequence of): Physician/Medical Examiner congestive heart failure week The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): atherosclerotic cardiovascular disease 5 years Box 68760 attending physician Due to (or as e consequence of): as the 980 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? P.O. the th 1 Yee 2 No 3 Probably 4 Unknown signed by chronic renal failure þ of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? director, page 2 should Be Completed 24a. Was an eutopsy this certificate has 1 Yes 2 No 1 Tyes 2 No. Physician: 25. Was cese reterred to medical 26. Place of Death (Check only one) Hospital: 1 ∏Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1□ Yes 2√ No Certification: To Director: After third in by the funeral 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Attending Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by or A after 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 15 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and menner as stated.
26 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner steted. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of cartifier 29c. License number December 26, 2000 Mann D0025759 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 21520 Box PO 247, 106 Cemetery Rd, Accident MD M. D. , Walter K.
31. Date filed (Month, Day, Naumann' 32. Registrar's Signeture State DEC 2 7 2000 Registrar

**DHMH 16 Rev 6/95** 

We the the the

DEC 2 2 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2642

							Certific	ate of	Death		Reg. No	).			
Physicia:	-	1. Decedent's Name (First, Midd		Reube	n Les	lie	Dil	ler		2. Dete of De Month Decembe	eth De		Year 000	3. Time of t	
/Medica Examine	_	4e. Fecility Neme (If not institution 20660 Miller							4b. City, Town, o	r Location of Deat		. County			
uneral irector		5. Social Security Number 220-34-2215 Usuel Residence of Decedent	6. Sex 1 🕮 M		Age (In yrs		hday) If Un Mont	der 1 Year ha Days			th y, Year 19	11	9. Birthp Coun Mary	place (State or htry) y l and	Foreig
28a-f show	5	10a. State 10b. County	ingto	0			or Location						1	0d. Inside City	
t be notify	Director	10e. Street end Number 20660 Miller				agei		10f. Zip Code 10g. C					Citizen of Whet Country?		
0 = 1	by Funeral	11. Meritel Stetus  1 Never Married 2 Mar 3 Widowed 4 Divorced	12. y	Wes Decede Armed Force   Yes 2   Yes, Give Yeer or Dete	ent Ever in les?	J,S.			Hispenic Origin? ben, Mexican, Pue	(Specify Yes or No erto Rican, etc.)		14. Rece - American Indien, Bleck, White, etc. Specify: White			
than 'natural', the Medical Exa	Completed	15. Deceder (Specify only highe Elementery/Secondery (0-12)	st grade co	on m <i>pieted)</i> College (1-4)	or 5+)	16e.	Decedent's L (Give kind of life. DO NO Farme	work done T use retire	petion during most of w	rorking		agric			
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Tart P	2	19e. Informent's Neme/Reletions				106	Malling Adds	nee (Stree				or Tour	Ctata 7in	Codel	
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important: if item 27 is marke any injury or other traumatic ance.		20e. Method of Disposition  1 X Buriel 2 Cremetion 4 Donetion 5 Other (S	3 □Remo			Place of	Disposition (	Name of or other ple		Dete 12/23/00	20c. L	ocation -	City or To	wn, Stete	
any in		21. Signeture of Funerel Service  23a. Pert1. Enter the disease, or shock, or heart feilure. List	2un complicatio	new ons thet cau	_ S∞	th. Don	Zimme 45 S	end Addr erman Car	ess of Fecility And Son lisle St	Funeral Greence	astl	e e, P	a. 17	7225 Approximete	
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by the teched	Physician	Pert II. Other significant condition	ens contribu	iting to deati	h but not res	utting in	the underlyin	g cause g	iven in Pert I.	23b. Did tobacco use contribute to the cause of c					
2 should be	pleted by									24a. Wes	en euto med?	psy	COL	ere eutopsy fin elleble prior to mpletion of ca deeth?	)
page page	5									10	Yes 2	No	1 🗆	Yes 20 N	No
director, pag	0	25. Wes case referred to medica examiner?								eeth (Check only o	ne)				
E E		1 ☐ Yes 2 No	Hospi	1 LI Inpa		ER/Out		LOA	her: 4 Nursing	Home 5 Resid	dence	6 □Othe	r (Specify	0	
ed in by the funer	IICATION	27. Manner of Deeth  1 Neturef 5 Pendir 2 Accident Investi 3 Sulcide 6 Could determ	not be	Ba. Dete of I (Month,		-11	me of jury M m, street, fec		ry at ork? ] Yes 2 □ No	28d. Describe				l Route Numb	oer.
		29e. Certifier 1 Certifyin	g Physiciae	building,	etc. (Speci	y) wledge.	deeth occurr	ed et the ti	me, dete end ple	City or Tou	vn, Stati	e)	ner as st	eted	
he Funer pletely fill	2	(Check only 2 Medical one)	Examiner: (	On the basis and manner	s of exemine	tion end	or Investiget	lon, In my	opinion, deeth oc	curred et the time,	dete en	d ptece, a	nd due to	the cause(s)	
To the comple	-	29b. Signeture and fitle of certifle	Hem	~					se number 043466				,	Day, Year)	
		30. Name and eddress of person	who comple	ted cause o	of deeth (Iter	n 23e) (1	Sucha	Ver V	ruil Eus	FE She	20	Crone	, P.	A 172	176
State		31. Dete filed (Month, Day, Year)	2000	32. Regi	strer's Sign	eture	A	Anc.	M. I		9		,		

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Year Dorothy Lucille Doule 23 2010 0102 December 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Washington County Hospital Hagerstown Washington 8. Dete of Birth Month, Day Year) 28 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 9. Birthpleca (Stete or Foreign Hours 1 M 20 F Months Days Maryland 71 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 1 Yes 2 No Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 13516 Herman Myers Rd. 21742 U.S.A 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Raca - American Indien Black, White, etc. 1 ☐ Yes 2 ☑ No Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) Seamstress Interiors

Itsm 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at death 72 hours after altimore, Maryland 21215-0036 should be filed within Hygiene. h end Mentel h permit. Pages 1 end 2 sh Depertment of Health end Important: If Itsm 27 Is m any Injury or other traun page.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

5. Social Security Number

212-24-3764

10e. Street and Number

11. Marifel Stetus

10a State

Md.

Director

**Physician** /Medical Examiner

the death certificate be execu Box 68760

Division of Vital Records, P.O.

attending physician and for use as the burial-fram 88 signed by 90 page 2 should peen certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies

Funeral 1 Never Merried 2 Merried by 3 ☐ Widowed 4 ☐ Divorced Completed Elementery/Secondery (0-12) 12 17. Fether's Neme (First, Middle, Last) Be Harry L. Frey Sr. 10 19e. Informent's Neme/Reletionship (Type, Print) Franklin Doyle (Husband) 20a. Method of Disposition Buriel 2 Cremetion 3 Removel from Final Donation 5 Other (Specify) Signature d Funerel Service Licenses 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Examiner Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Physician/Medical by Completed 25. Wes case referred to medical Be 1 Yes 2 No 2 27. Menner of Deeth Certification: 1 Neturel
2 Accident 3 ☐ Suicide 4 \ Homicide

OVARIAN CARCINOMA BOOMINA

20b. Piece of Disposition (Name of cemetery, cremetory or other piece)

Rest Haven Cemetery

22. Neme and Address of Fecility

18. Mother's Neme (First, Middle, Maiden Surneme)

Dete

Dec.28,

Davis Funeral Home Smithsburg, Md. 21783

19b. Meiting Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)

13516 Herman Myers Rd. Hagerstown, Md. 21742

Naomi C. Smith

Part II. Other eignificant conditions confributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown

20c. Location - City or Town, Stete

Hagerstown. Md.

12525 Bradbury Ave.

24a. Wes en autopsy 1 Yes 2 0 No 24b. Were eutopsy findings aveilable prior to completion of cause of death?

Approximate Interval Between Onset and Death

26. Plece of Death (Check only one)

1 ☐ Yes 2 ☐ No

5 Pending investigation

28e. Dete of Injury (Month, Day Year) 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Hospitel:

1 Dinpatient

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how Injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end pleca, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and pleca, end due to the cause(s) end menner stated.

29b. Signetur

29c. License number

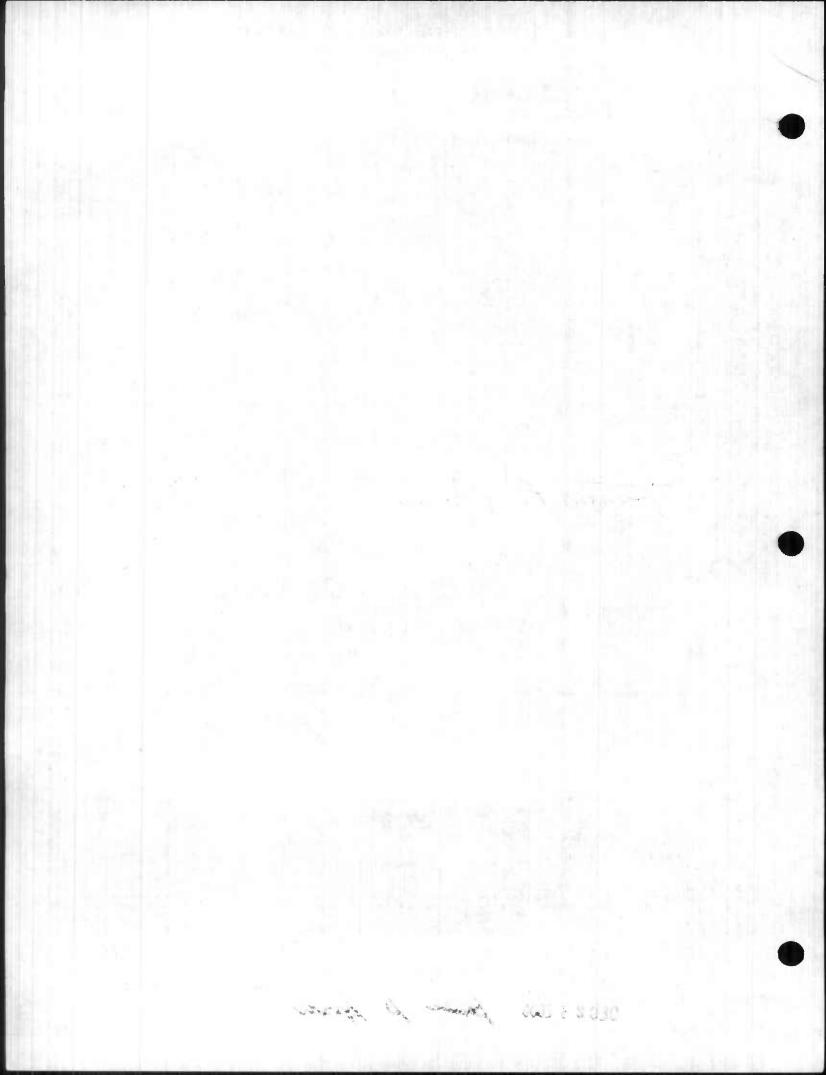
29d. Date signed (Month, Dey, Year)

State Registra

completely

Medical





#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 42666 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month EUGENE DAY 25, 2000 2:30 PM December 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Charlotte Hall Charlotte Hall Veterans' Home Months Days Hours Min. B. Date of Birth (Month, Day, Yeer) 9. Birthplace (Stete or Foreign March 20, 1909 Virginia 5. Social Security Number 7. Age (In yrs. lest birthday) 1 X M 2 □ F 577-07-7797 91 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes X No Maryland St. Mary's Mechanicsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20659 40243 Wolf Drive USA 12. Was Decedent Ever in U,S. Armed Forces? 14 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 1 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Gas Fitter Washington Gas Co. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Beulah Ann Carrico William Harrison Day 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6226 NE - 1ST Street, Ocala, FLA 34470 Eugene R. Day - Son 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State Maryland Veterans' Cemetery 12-29-00 Cheltenham, MD 4 Donetion 5 ☐ Other (Specify) Funeral Service Linde 21. Signature of 22. Name and Address of Facility Huntt Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximete Intarval Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in death) PNEUMONIA 2 WEERIS Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated evants rasulting in deeth) Lest Due to (or as e consequence ot): Due to (or es e consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown TO THRIVE 24a. Wes an autopsy performed? 24b. Wera autopsy tindings aveilable prior to DEHYDRATION complation of ceuse of deeth? CONGESTIVE 1 Yes 2 Sto 1 ☐ Yes 2 ☐ No

Physician /Medicai **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

r than "netural", or items 23e or 28a-f show

Hygiene.

permit. Peges 1 and 2 should be filled w. Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other treasment.

21215-0020

Baltimore, Maryland

Director

Funeral

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Completed

Be

-tren pue physiclan the 98 ettending p signed by t pege 2 director this

The law requires that the death certificate be executed

Box 68760,

P.O.

Records,

of Vital

Division

Examiner Certification: To is or Attanding P setter deeth.

I Director: After tid in by the funere To the Hospital or within 24 hours eft To the Funeral Di completely filled in

by Be Completed

Medical

Physician/Medical

25. Was cese referred to medical exeminer?

1 Yes 2 XNo 27. Mannar of Deeth f SANaturel

2 Accident 3 ☐ Sulcide 4 Homicide

29a, Certifier

investigation 6 Could not be datemined

28e. Data of Injury (Month, Day Year) 5 Pending

1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify)

28b. Time of

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

26. Pleca of Daeth (Check only one)

Other: Sursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

28t. Location (Street end Number or Rural Routa Number, City or Town, Stete) 1 Dertifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the cause(s) and menner as stated.

2 Medicat Examtner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, data and place, end due to the ceuse(s) and mannar stated.

(Check only one) 29b. Signature and title of certifier

29d. Detesigned (Month, Dey, Year) 12 2000

30. Name and address of person who completed ceuse of death (Itam 23e) (Type, Print)

31. Date tiled (Month, Dey, Yaar)

32. Registrar's Signeture Depera DEC 2 8 2000

102

State Registrar

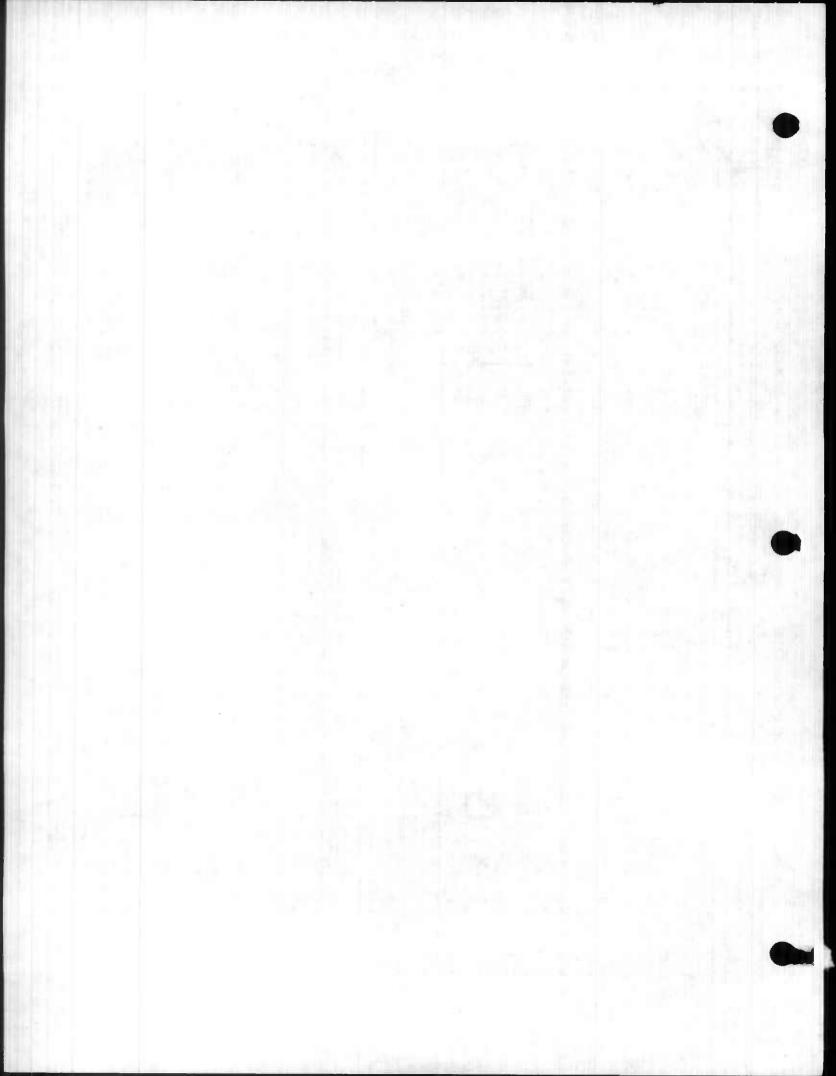


Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28 Month **Physician** 23:05 WILLIAMS 12 00 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner worl61 Lien 405 If Under 1 Year 6 Sax 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign County) Mary Land 5. Social Security Number **Funeral** Hours 10M 20 F Months Days Min 212-20-700 Yrs. 22 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3926 Old Columbia Pike 21043 United States 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 72 hours after 1 DYes 2 No
If Yes, Give 1946
Year or Datas: 1946 1 Never Merried 2 Narried Maryland 21215-0020 1 Yes 20No Specify: Specify: white p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry s 1 and 2 should be filled within if Health and Mental Hygiens. Hem 27 is marked other than " Hypiene. College (1-40(5+) Elementary/Secondery (0-12) Real Estate Developer Real Estate 17. Father'a Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Be Turner Read Fulton, Sr. Jessie Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If them 27 is n Melissa Fulton / spouse 3926 Old Columbia Pike Ellicott City, MD. 21043 altimore, 20b. Place of Disposition (Name of camatery, crematory or other place) Dec.30 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burlal 2 Cramation 3 Removal from State
4 Donation 5 Other (Specify) ö 2000 Metro Crematory Catonsville, Maryland 21. Signature of Funeral Service Licansee 22. Name end Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4112 Old Columbia Pike Ellicott City, MD.21043 Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) 30 minu 4 Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting In death) Last as the burial-tran the attending physician and Dua to (or as a consequence of): use 10 detached Part II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by 1 Yes 2 Ne 3 Probably 4 Unknown of Vital Records, by 8 24b. Were eutopsy findings available prior to completion of cause of death? page 2 should Completed 24e. Was an autopsy performad? certificate has 1 ☐ Yes 2 ☐ No 1 Yes ARO Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred Attending 1; Natural 5 Pending investigation 1 Yes 2 No after death 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, streat, factory, offica building, etc. (Specify) filled in by 4 Homicide 5 To the Hospital o within 24 hours at To the Funeral D \* Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifiar 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) ZKnoll Kelomen M.

State Registrar 31. Date filed (Month, Day, Year) JAN 0 2 2

32 Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10 42646 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 0 1145 874 /Medical Neme (If not institution, give street and number) 4b. City\_Town, or Location of Deeth Examiner 0/214515 OWGV OWGVO If Under 24 Hrs. 8. Dete of Birth (Month, Dey, May 9, If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 25 F Months Deys Virginia 225 01 7283 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Hygiene. Important: If Itams 21s marked other then "natural", or Itams 23s or 28s-f show any Injury or other traumatic event. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Howard Ellicott City 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 3406 Tyler Drive 21042 United States by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes ♣ No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 3 ☐ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced white Be Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charles Coffman Clara Hoffman 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) James Forsyth/Husband 3406 Tyler Drive Ellicott City, MD 21042 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 12-29-2000 Catonsville, MD MOLD 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Physician/Medical Examiner Attending Physician: The law requires that the death certificate be executed burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In deeth) Lest P.O. Box 68760, physicien respirat the OVEVUS Part ti. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? Completed 1 Yes 1 ☐ Yes 2 ☐ No After this certificata director 25. Wes cese referred to medical Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient ≥ TER/Outpetlent 3□ DOA filled in by the funeral Certification: 27. Menner of Deeth 28d. Describe how injury occurred Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No daath. 2 Accident s after daath 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homleide 10 Hospital 24 hours Medicai the Certifying Physicisn: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medicet Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end plece, end due to the ceuse(s) end menner stated. 29a. Certifier To the Within 2 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ess of person who completed ceuse of deeth (Item 23a) (Type, Print) 10805 Hickory (Olympis Md

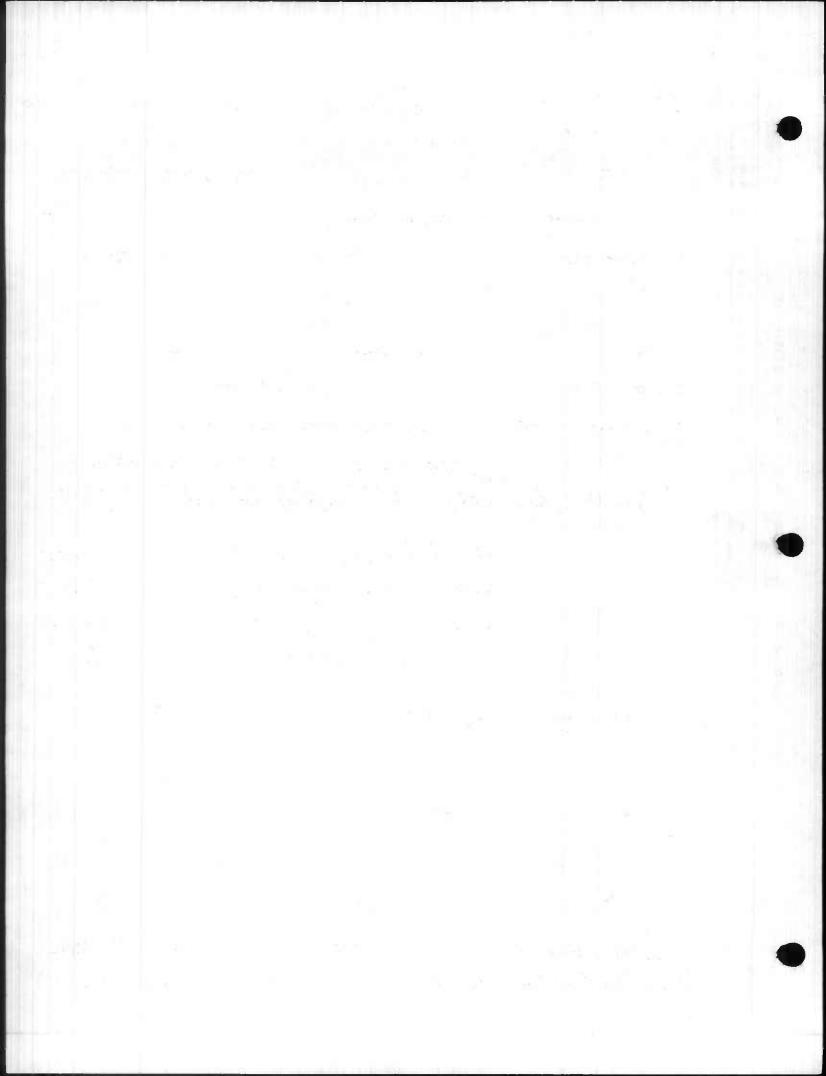
State

Registrar

31. Dete filed (Month, Dey, Year)

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32 Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 42647

				Certificate of	Death	R	eg. No.						
	1. Decedent's Name (First, Middle, I	.ast)				2. Data of Deal Month	th Day	Yaar	3. Tima of Death				
Physician /Medical	JACK WESLEY	FRIDINGE	R			DECEMBE		2000	9:44 PM				
Examiner	4a Facility Nama (If not institution, g	iva street and number)			4b. City, Town, or Lo	ocation of Death	4c. County	of Death					
	GARRETT COUNTY M	EMORIAL HOS	PITAL		OAKLAND			GARRETT					
Funeral Director	5. Social Sacurity Number 212-14-6768	Sex 1 M 2 F 7. Age 78	(In yrs. last birtl Y	rs. If Under 1 Yaar Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) AUG 19,	1922	9. Birthp Coun MAR	olace (State or Foreign) NATION YLAND				
p a	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				1	Od. Inside City Limit				
death with the Maryland ims 23s or 28s-1 show if must be not fied if neral Director	MD GARRET		OAKLA						1 ☐ Yes 2X N				
or 28s-f sho be notified at Director	10e. Street and Number		OTHCE	10f. Zip Code		1	0g. Citizen of V	Affret Cour	ntn/2				
Die Die	6724 OAKLAND-SAN	C PUN POAD		21550	1		USA	viiai Couii	iti y i				
mark 23s	11. Marital Status	12. Was Decedent Ev	ver in II S	13. Was Decedent of H		ecity Yes or No-		e - Americ	can Indian,				
or or he bearing	1 Naver Married 2 Married 3 Widowed 4 Divorced	Armed Forcas?		If Yes, specify Cub  1 ☐ Yes 2 No	an, Mexican, Puerto	Rican, etc.)	Blac	ck, Whita,	etc.				
"natural", or its social Exercine leted by Fu	15. Decedent's (Spacify only highast)	Education	16a. I	Decedent's Usual Occup (Give kind of work dona life. DO NOT use retire	pation	ing	16b. Kind of B	of Business/Industry					
- 30	Elementary/Secondary (0-12)	College (1-4or 5+	)			"ig							
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and Mental Innerked or urnetic eve	WILLIAM HENRY	FRIDINGER			HAZEI	TAYLO	R HAMM	IERSLA	A				
end sum sum	19a. Informent's Name/Relationship			Mailing Address (Street									
Health am 27 other tr	LAURA FRIDINGER	- WIFE		6724 OAKLAN	D - SANG								
Department of Health end Mental Hyglene. Important: If Itam 27 is marked other than any injury or other traumatic event, tha Mannes. To Be Complete.	20a. Method of Disposition	□ Pomovel from State	20b. Placa of cemetery	Disposition (Name of r, crematory or other ple	ce)	Date	20c. Location -	City or To	own, State				
Department of Personal Information of Important: If its any injury or of once.	4 Donation 5 Other (Spec	MORGA	RGANTOWN, WV										
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the a	Part II. Other significant conditions	contributing to death but	not resulting In	the underlying cause gi	ven in Part I.	23b. Did to	obacco uae co	ntribute to	o the cause of deat				
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00	examiner?	Hospitel:	2 ERVOU	patiant 3 DOA Ot	her: 4 Nursing Ho	ome 5 Resid	ance 6 Ott	ner (Specia	fy)				
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within 2 To the comple	29b. Signature and title of certifier	11		29c. Licen	se number	2	29d. Date signe	d (Month,	Dey, Year)				
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41	30. Name and address of person wh	o completed cause of dea	ath (Item 23a) (		,030		12/20	, 200	, ,				
141	Margaret Kai			Garrett	Highway	. Oakl	and. M	1d - 21	1550				
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Dev **Physician** John m 1025 peamber /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Washington County Hospital Hagerstown 6. Sex 1 XM 2 ☐ F If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Director July 1,1928 Hagerstown, 202-24-6349 Usual Residence of Deceden 10e. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Director MD. Washington Hagerstown, Maryland 10e. Street and Number 3407 Cherry Tree Circle 10f. Zip Code 10g. Citizen of What Country? 21742 Hagerstown, MD. U.S.A. Funeral 12. Was Decedent Ever in U,S. Amed Forces? 1.2 Yes 2 No H Yes, Give 9/16/46 Yeer or Dates: 7/26/48 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Board of Education Elementary/Secondary (0-12) College (1-4or 5+) Teacher 12 Supervisor of Music 18. Mother's Name (First, Middle, Meiden Surneme) 17. Father's Name (First, Middle, Last) Be John Fignar, Sr. Helen Wahal Fignar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemarie Fignar/Wife 13407 Cherry Tree Circle, Hagerstown, MD 21742 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremetion 3 ☐ Removal from State Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 12/23/2000 22. Name and Address of Facility Douglas A. Fiery FuneralHome 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. N., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequença of) Physician/Medicai Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of death? Completed Pusity Cooliousse 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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filed within 72 hours after

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Pages 1 and 2 should be fill mant of Health and Mental Heart: If Item 27 is marked oth lury or other traumatic even

Department of important: If any injury or

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Division of Vital Records, P.O. Box 68760,

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Baltimore, Maryland 21215-0036

than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

30. Name, and add

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 42649

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Y	dical niner		(If not institution, giv		mber)				4b. City, To	own, or L	ocation of Death	4c. Count		2.05 11.		
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Funer	al le	5. Social Security			7. Age (In yrs. la	st birthday)	If Under		If Under	24 Hrs.	8 Date of Birth		9. Birtho	place (State or Forei		
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21215-0020 d within 72 hours after death with the Maryland piene. piene. gran "natural", or frame 23a or 28a-f show or see the professional Earnalise management of the professional profes	by Funerai		rried 2 Married 4 Divorced	12. Was Dece Armed Fo 1  Yas If Yas, Giv Yaar or Di	21 No		Was Deced If Yes, spec	- 01	lispanic Or an, Mexica Specify		ecify Yas <i>or</i> No- Rican, atc.)	Bla	14. Race - American Indian, Black, Whita, atc.  Specify: WHITE			
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Ling. Perment		4 Donation	5 ☐ Other (Specif	y)	BOO	NSBOR	O CEM	ETER	RY	12	2/26/00	BOONS	BORO,	MARYLAND		
Baltim permit. Peg Deperment Important: I	ġ	21. Signature of Foorth Sarvice Accessee  22. Name and Address of Facility 7606 Old National Pike														
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		23a. Part L. Entar	tha disaase, or com	plicetions that c	aused tha death.	Do not ent	ar the mod	le of dyir	ng, such as				yland	Approximata		
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, P.O. Box 68760, that the death certificate be executed ted by the attending physicien and deteched for use as the buriel-trensit	Examiner	Sequentially list or	onditions,		Due to (or a	as a conseq	quence of):	1	11.	1	1					
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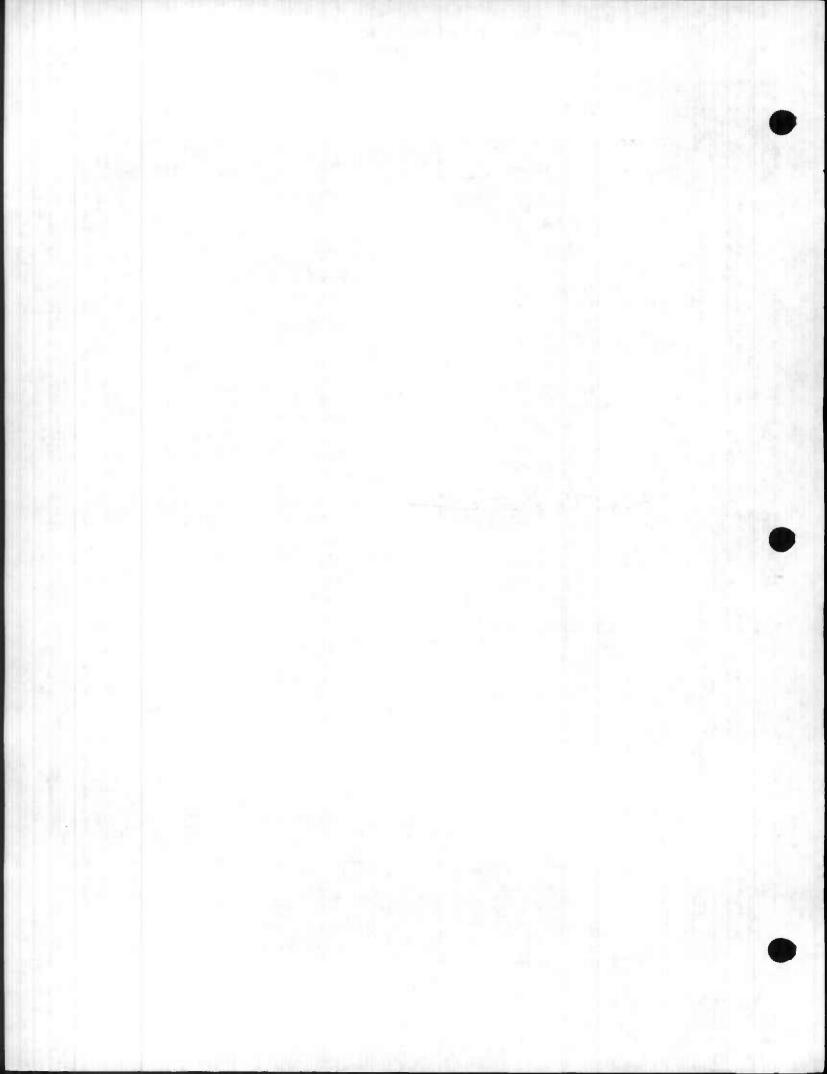
### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** DECEMBER 5, 2000 10:00 PM **GLADYS** R. FIROR /Medical 4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Min. 1 M 2 F Hours Months Days 217-09-0926 86 Director Feb. 3, 1914 Maryland Usual Residence of Decedent the Marylend 10c. City, Town or Location 10d Inside City Limits 10a. Stete 10b. County tem 27 ie merked other than "natural", or itema 23a or 28a-f ehow other treumatic event, die Medicel Examinar mant te notified all 1 Yes 2 No Directo Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13812 Pryor Road 21788 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ØNo If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: à 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th end Mental Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Seamstress Claire Frock 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be William Washington Ridenour Mildred Amelia Pryor 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) os 1 and 2 sof Health er Item 27 ie Floyd McAfee (Administrator) 13713 Pryor Road, Thurmont, Maryland 21788 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any injury or o 1X Burial 2 Cremation 3 Removal from State Blue Ridge Cemetery 12/9/00 Thurmont, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788 2 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Betw Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in deeth) /Medical ARCINOTA OF THE BLADDER YEARS Examiner Due to (or as a consequenca of) Examine ettending physician and for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. P 24b. Were eutopsy findings 24a. Was an autopsy performed? Completed available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medicat examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 KNo 2 this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: or Attending Peter deeth. 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and manner es steted. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1) 10587 VPMA 2000 4.10. FREDERICK MEHORIA- MONITAL 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) VICE-PRES HED AFFAIRS FREDERICK SHITH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 8 2000

**DHMH 16 Rev 6/95** 

Registra



			State of Maryland / Department of Health and Mental Hygiene 465   Certificate of Death Reg. No.  1. Decedent's Nama (First, Middle, Last)   2. Data of Death   3. Tima												
	Physicia	_	Lawrence Edward I		Sr.					Decemb	Day O.				
	/Medic Examin		4a Facility Nama (If not institution, gir		mbar)				4b. City, Town,	or Location of De	ath 4c. County	of Death			
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	Be-f show	Director	Maryland Frederic	2k		ty, Town or I derick						10d. Inside City Limits 1 ☐ Yas 2 ☐ No			
	23a or 2		1705 Heather Lane				217				10g. Citizen of USA	What Country?			
020	within 72 hours efter death with the Maryland ene. Than "netural", or thems 23s or 28s-f show the Medicel Examinar must be notified at	by Funeral	11. Marital Status  1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Apped Fo 1 (2) Yas If Yas, Giv Yaar or D	2 No 19	43-	. Was Deci If Yas, sp 1 Yas		dispanic Origin: an, Maxican, Pi Specify:	? (Specify Yas or I uarto Rican, atc.)	No- 14. Rac Bla Specify	ce - Amarican Indian, ck, Whita, atc. y: White			
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ary	of Heal Rem 2		19a. Informant's Name/Ralationship	9	-17	19b. Ma	iling Addras	s (Street			nber, City or Town,	, Stata, Zip Code)			
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Baitimore,			20a. Mathod of Disposition  1X Burial 2 ☐ Cramation 3 ☐  4 ☐ Donation 5 ☐ Other (Special Content of the Conten	y)	State	Placa of Disposamatary, cr. Oliv	amatory or	othar pla		12/12 2000		- City or Town, Stata - Ck, Maryland			
Bai	permit. Page Depertment of Important: If any injury or page.		21. Signature of Funeral Service Lice	Bo.0		0999	106 E	Cast		Street,	Frederic	ord Funeral Homek, MD 21701			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heelt failure. List only one cause of each line.												
	Physician /Medical Examiner		Immediata Causa (Final disaasa or condition rasulting in daath)	a. Conge	years										
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O. Box	that the death ed by the atter detached for a year of the property of the prop		Part II. Other significant conditions of	ontributing to de	eath but not ra	sulting in tha	underlying	causa gi	ven in Part I.	23b. D	id tobacco use co	ontribute to the cause of death?			
			Previous Sepsis	3						_ 11	☐ Yes 2Ñ No	3 Probably 4 Unknow			
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	tending leath. for: After the fune		1 Natural 5 Panding 2 Accidant invastigatio 3 Suicida 6 Could not be determined	(Month, Day Year) Injury Work?  I ☐ Yas 2 ☐ No  28a. Placa of Injury - At homa, farm, street, factory, office 28f. Locatio						28f. Location	n (Street end Numi Town, Stete)	ber or Rurel Route Number,			
۵		edical Cert	29a. Certifying Pi	ysfcfan: To tha		owledga, daa				lace, and dua to the	ne cause(s) end m	anner es stated. end due to tha cause(s)			
	To the H within 24 To the Fi complete	Med	one)  29b. Signatura and titla of certifiar		ner steted.	and and of			se number	To the time time		ed (Month, Dey, Year)			

State Registrar

DHMH 16 Rev 6/95

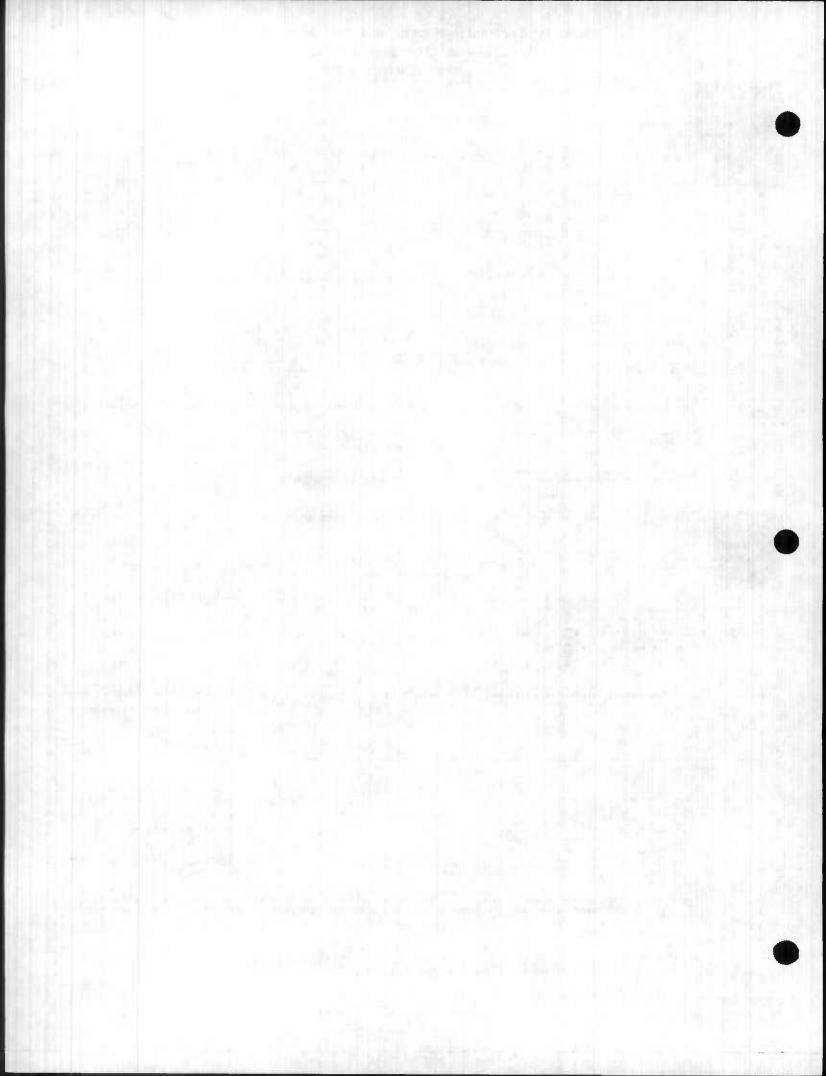
John Vitarello, MD, 180 Thomas Johnson Drive, #202, Frederick, Maryland 21702

31. Data filed (Month, Day Year) 1 2000 32. Registrer's Signature

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

D27544

December 11, 2000



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible 1, 2 6 5 2 State of Maryland / Department of Health and Mental Hygiene

		Certificate of	Death	Reg	. No.									
	Decedent's Nema (First, Middle, Last)			2. Data of Death Month	3. Time of Deeth									
Physician /Medical	Homer James Glot	felty	The Contract		Dey Year 27,2000	2215 p.								
/Medical Examiner	4e Facility Nama (If not institution, give street end number)	Terch	4b. City, Town, or Loc		4c. County of Dea									
Examina	Sacred Heart Hospital	Cumberland		Allega	nu									
Funeral	5. Sociel Security Number 6. Sex 7. Age (In	n yrs. lest birthdey) If Under 1 Year	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Dey, Y	9. Bi	rthplece (Stete or Fore ountry)								
Director	213-22-2179 XXM 2DF	87 Yrs. Months Deys		Nov. 1.19		yland								
100	Usuel Residence of Decedent					-								
T Line	10a. State 10b. County 10	C. City, Town or Location				10d. Inside City Lim								
28a-1 notifie recto	Maryland Allegany	Frostburg				iXOXYes 2□1								
or 28s-f	10e. Street and Number	10f. Zip Code		10g	. Citizen of What C	ountry?								
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iners 23 siner mail Funeral	316 Braddock Street, Apt, 310 11. Marital Stetus 12. Wes Decedent Eve Armed Forces?	r in U,S. 13. Wes Decedent of I	Tispenic Origin? (Specen, Mexican, Puerto R	7 (Specify Yes or No- uerto Rican, etc.) 14. Râce - American Indies Bleck, Whita, atc.										
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Erand d	3 ¼ Widowed 4 ☐ Divorced Year or Datas:					White								
ygions. Ar the Medical. Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usuel Occup (Give kind of work done life. DO NOT use retire	pation during most of working	7 16	b. Kind of Business	s/Industry								
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Hote as	17. Fathar's Neme (First, Middle, Last)		18. Mothers Neme	Neme (First, Middle, Maiden Sumema)										
To Mo	James Glotfelty		Nora Tu	4										
and and	19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Straet	and Number or Rural	Route Number, C	City or Town, Stete,	Zip Code)								
n 27	Larry L. Glotfelty//Son	P.O. Box 505;	Shippenyi	lle, PA	16254									
5 2 2	200. Mildi loc di Disposition	<ol> <li>Plece of Disposition (Neme of cemetery, cremetory or other pla</li> </ol>	ca)		c. Location - City o	r Iown, State								
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Port of	21. Signature of Funaral Service Licensia	ess of Facility	nes, P.A.											
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Registrar	DEC-2 9 2000	S. Assaul	ale .											

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death DONALD EUGENE GRIFFITH 24, 2000 DECEMBER 15:00 AM 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) REEDERS MEMORIAL HOME BOONSBORO WASHINGTON Hours Min. 8. Data of Birth (Month, Day, Year) AUG. 2, 193 If Under 1 Yaar Birthplace (Stete or Foreign Country) MARYLAND 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Days 1 MM 2 □ F Yrs 63 216-38-2221 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No SHARPSBURG MARYLAND WASHINGTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4533 HARPERS FERRY ROAD 21782 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Nevar Marriad 2 ☐ Married 1 ☐ Yas 2 ☒ No If Yas, Giva 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantery/Secondary (0-12) Collega (1-4or 5+) LANDSCAPE COMPANY 10 LANDSCAPER 18. Mother's Nama (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middle, Last) GEORGE WILLIAM GRIFFITH GENEVA LEE LAFOLETTE 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4529 HARPERS FERRY ROAD, SHARPSBURG, MARYLAND 21782 JUNE KEYTON/SISTER 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Date 1 ⊠ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 12/27/00 SHARPSBURG, MARYLAND MOUNTAIN VIEW CEMETERY 21. Signature of Funeral Service Lidensee 22. Nama and Address of Fecility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23a. Part1. Enter the disease-for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Final disaasa or condition rasulting in death) One year Dua to (or as a consequence of): Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Cause (Disease or injury that initiated avants Due to (or es a consequence of): Dua to (or as a consequence of): rasulting in daath) Last 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 ☐ Yes 1 Tas 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

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Box

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within 24 hours a To the Funeral C completely filled Hospital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Peges 1 end 2 should be filed within nent of Health end Mentel Hygiene. int: if item 27 is marked other than \*

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Physician/Medical Examiner chysician end the burial-transit by Completed Be edical Certification: To rector:

25. Was casa rafarrad to medicel

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6 Could not be determined 3 Suicida 4 Homicida 29a. Cartifiar

and mannar stated.

Plece of Injury - At home, farm, street, factory, office building, atc. (Specify)

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Flural Floute Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and mannar es stated.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signatura and titla of certifian

29c. License number D 44996 29d. Data signed (Month, Day, Year)

30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

334 MILL STREET HAGERSTOWN, MARYLAND 21740/ 301-739-7100 DR. VASANT DATTA

State Registrar 31. Data filad (Month, Day, Year) DEC 2 6 2000

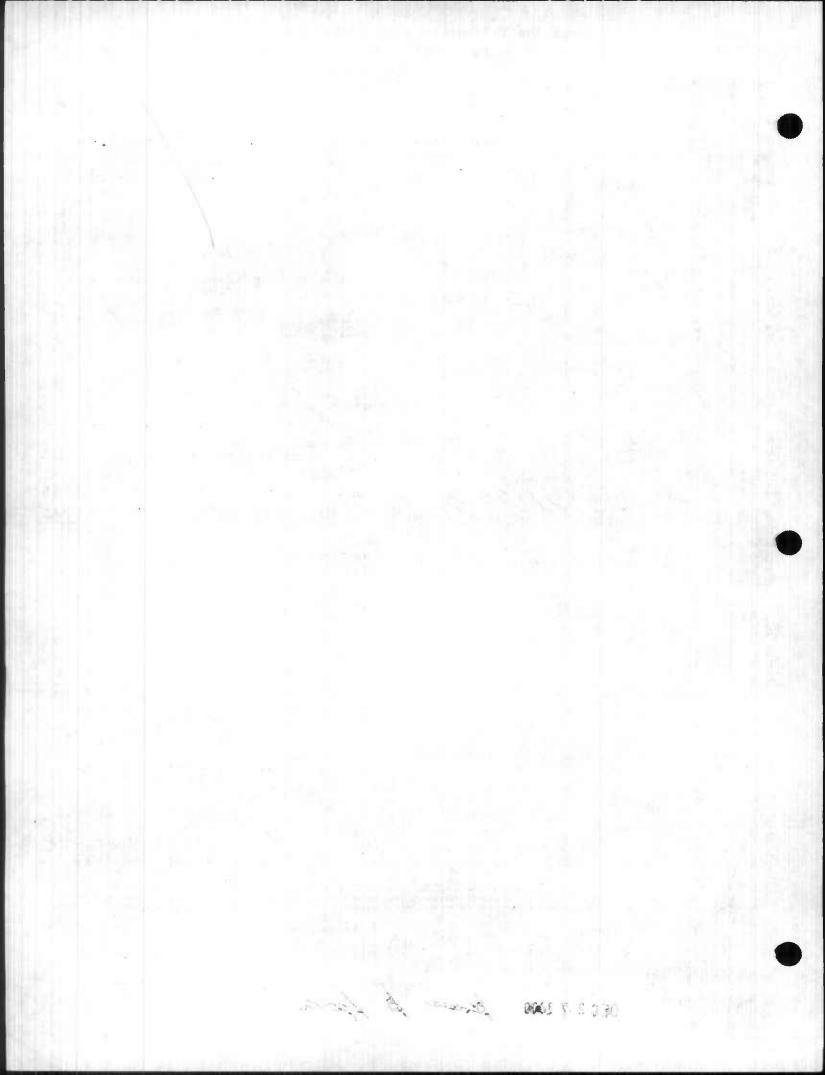


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State of Maryland / Department of Health and Mental Hygiene 1 1, 2 5 51

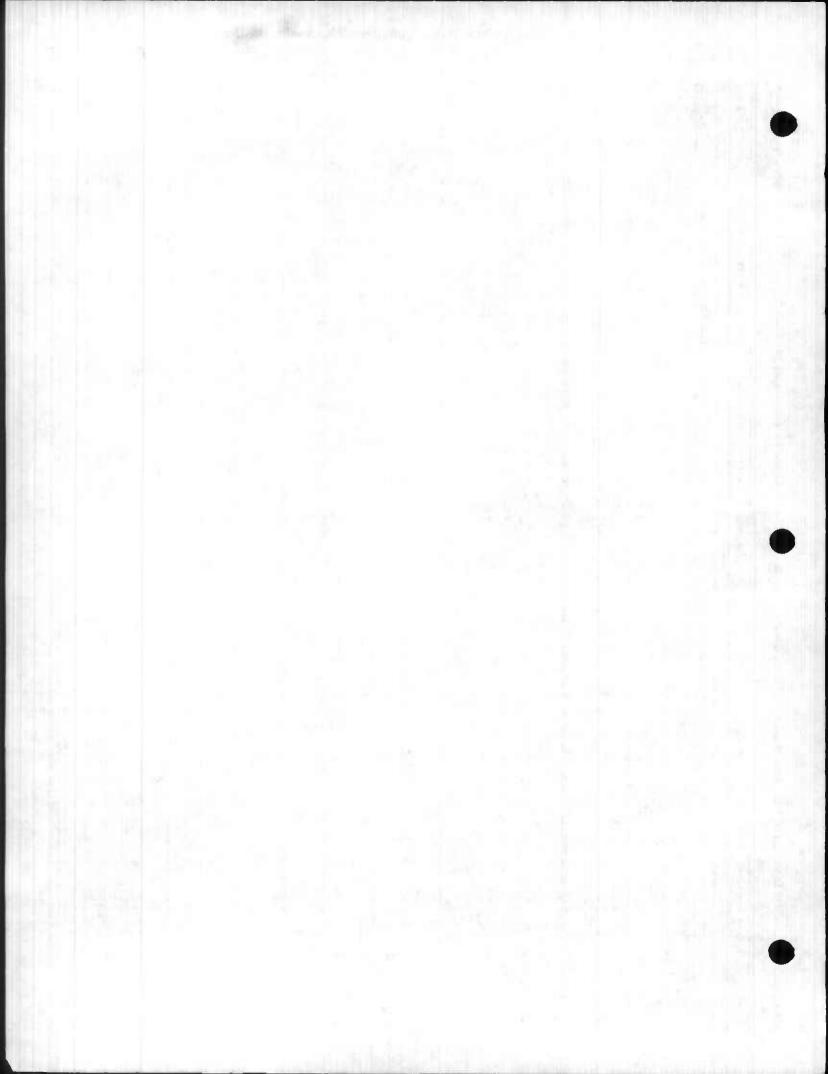
Robert	Andrew	Certificate of Death Reg. No.											
		1. Decedent's Name (First, Middla, La	ist)						2. Data of D	eath		3. Tima of Death	
	Physician	Robert A	ndrew	Couff					Decemb	er 20	2000	03:00 P.M	
	/Medical Examiner	4a Facility Name (If not institution, gir					4b. 0	City, Town,	or Location of Dea		ounty of Death	00000 2 000	
	Examino	112 No.	th Canr	non Aver	nue		+ 1	Hager	stown		Washin	aton	
	Funeral		Sex	7. Age (In yrs.	last birthday,	If Under 1 Y	raar If	Undar 24 F	Irs. 8. Dete of B			place (Stata or Foreign ntry)	
	Director	219-92-0272	1 ☑ M 2 □ F	36	Yrs.	Months D	ays r	iours iv	Jan.		64 Mary	land	
7		Usual Rasidence of Decedant											
3	a la	10a. Stata 10b. County		10c. Cit	y, Town or Lo							10d. Inside City Limits  YE Yes 2 □ No	
3	000	Maryland Washin	gton		На	agerstov	wn						
4	23e or 28e-f show	10e. Street and Number				10f. Zip Co				10g. Citizer	of What Cou	ntry?	
free Methods	23 E	112 North Cannon	Avenue				1740		1000	USA			
-	r itema 234	11. Marital Status	12. Was Dec Armed Fo	edant Evar in U orcas?	, <i>S</i> . 13.	Was Decedant If Yas, specify	t of Hispa Cuben, N	inic Origin? Maxican, Pu	(Specify Yes or Nuerto Rican, atc.)	10-	Race - Amari Black, Whita,		
36	0 0	1 Nevar Married 2 Married	1 🗌 Yas If Yas, Gi	va		1□ Yas 2⊠	No S	pecify:		Specify: White			
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	the and Mentel Hygiene.  7 is marked other than traumatic event, treatments.  To Be Comp.	19a. Informant's Name/Ralationship William J. Gouff		rother		N. Cann							
	Heal The The	20a. Method of Disposition	Di			osition (Name of		verrue	Data	-	tion - City or T	nd 21740	
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	hysician /Medical Examiner	shock, or haart failura. List only Immediate Cause (Final disaasa or condition resulting in deeth)	ona cause on	each line.		YSHOT			OF THE			Intarval Batween Onsat and Death	
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	nding physicia use as the bur	that initiated evants  Due to (or es e consequence of):											
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ords, P.O. Box 68	signed by the attending ph d be detached for use as the d by Physician/Med												
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I Re	page 2								10	Yas 20	No 1	Yes 2 No	
ta .	certificate has rector, page 2	25. Was cesa rafarred to medicel					21	6. Place of	Daath (Check only		-		
of Vita	s certific director,	examiner? 1∆ Yes 2 No	Hospital 1	Inpatient 2	ER/Outpatie	nt 3EI BOA	Other:		ng Homa 5 □ Ra		Other (Spec	ity) Scene	
Division of Vital	After thi funeral	27. Manner of Death  1  Natural 5  Pending  2  Accidant Invastigation	28s, Date	g triury of Day Year)	28b. Time of Injury 2:45	(Found) 80	Injury at Work? 1 Yes	/	28d. Dascrib	e how injury o	occurred	SELF	
Divis	To E Da	3 Suicide 6 Could not to datamined	build	e of Injury - At It ling, etc. (Specif W.C.		treet, factory, of	ffice		28f. Location Gity or T	(Street and I	Number or Ru	ral Routa Number, Maryland	
	within 24 hours To the Funeral completely filled	29a. Certifier (Check only one)  1 Certifying Pl	miner: On tha b	a best of my kno pasis of axamina nnar stated.	owledga, deat ition and/or Ir	th occurred at the example of the ex	the tima, my opini	date and pl on, daath c	lace, and dua to beccurred at the time	causa(s) ar a, data and pi	nd mannar as lace, and dua	stated. to the cause(s)	
To a	To the comple	29b. Signature end title of certifiar	tifiar 29c. Licanse number 29d. Data signed (Month, Day, Year)										
		30. Name and all crass of person who completed ceuse of deeth (Item 23a) (Type, Print)  SEP RESTANCE 111 Penn Street, Baltimore, Maryland 21201											
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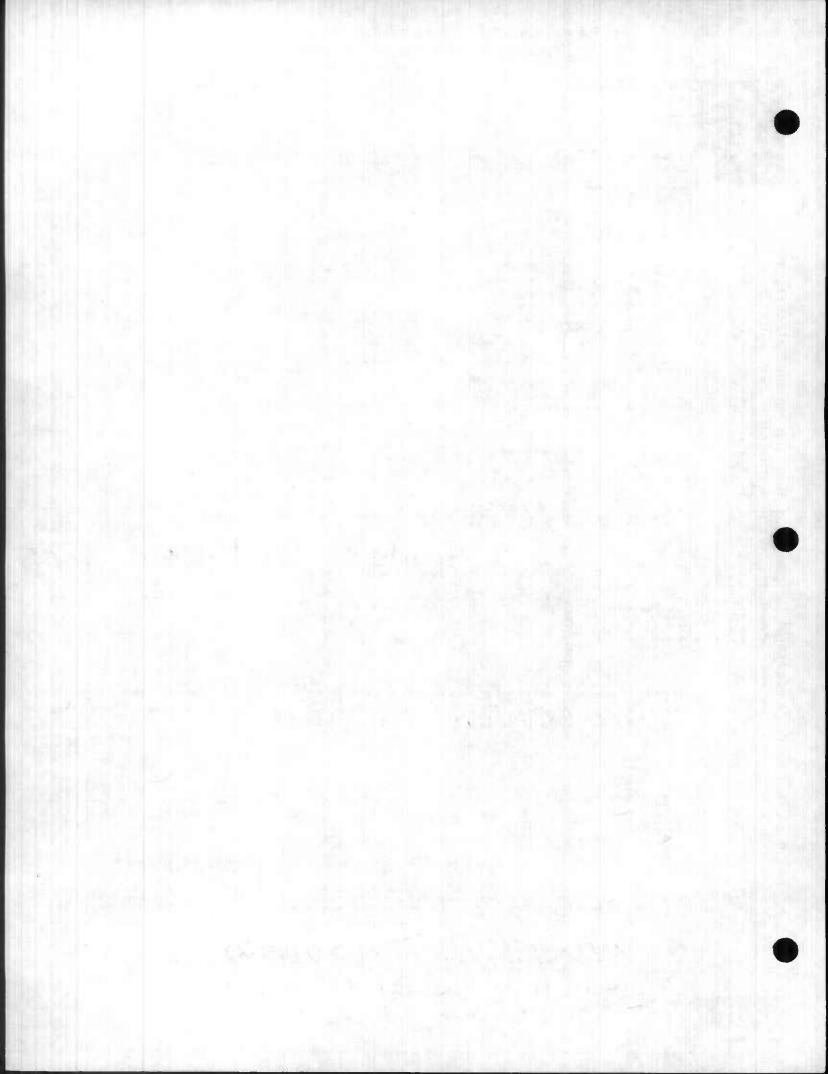
State of Maryland / Department of Health and Mental Hygiene 0 0 4 2655

							Certificat	e of	Death		Re	g. No.	Light	200	9
			1. Decedent's Name (First, Middle, L	ast)							2. Date of Death		Year	3. Time of	Death
	Physicia: /Medica	-	Donald W.	Gue							Decemb		2000	2:05	PM
	Examine	_	4a Fscility Name (If not institution, ga	ve street end number	)	1	lo kara		4b. City, To	wn, or Lo	cation of Death	4c. County	of Death		
-			Frederick Memori							eder			eder		
	Funeral			1 N M 2 T E	ge (In yrs.		rs. If Under	1 Year Days	If Under Hours	24 Hrs. Min.	B. Date of Birth (Month, Dey,	Yeer)	9. Birthp	lace (State or etry)	Foreign
	Director		192-09-4670 Usuaf Residence of Decedent		83		13.				April 20	,1917	Penr	nsylvar	nia
	hend wo		10a. State 10b. County		10c. Cit	y, Town	or Location	775					1	0d. Inside Cit	y Limits
	the Maryler 28a-f show nothed at	ō	Maryland Montgo	merv	Dama	ascu	S							1 🗆 Yes	2⊠ No
	or 284	Director	10e. Streel and Number		Dam	4000	10f. Zip	Code			10	g. Citizen of V	Vhel Coun	ntry?	
	th wit	a	P. O. Box 251					208	72			United	Sta	tes	
	Hems Inst. m	Funeral	11. Marital Status	12. Was Decedent Armed Forces		,S.	13. Was Deced	dent of I	Hispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Rac	e - Americ	an Indian,	
215-0020	or.	P	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	No	II			Specify:			Specify			
5-0	natural',	Completed	15. Decedent's E (Specify only highest g	ducetion		168	Decedent's Usua (Give kind of wo	al Occu	pation	t of worki	ina	16b. Kind of Bu	siness/Inc	dustry	
2	within ene.	nple	Elementary/Secondery (0-12)	College (1-4or	5+)		(Give kind of wo life. DO NOT u			t Or WORK	.,9				
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Ö	Ped Fig		k hll A	1 Miners	1						P. A.,				
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	/Medical		Immediate Cause (Final disease or condition	RES	CIRA	TRL	FAIL	.200						2. m	(2)
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68760,			Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events												
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 50 4 2656 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death December 11 **Physician** 2000 5:20 a.m. ROSCOE MEREDITH SR. GRIMES, /Medical 4a Facility Nama (ff not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) If Undar 1 Yaar 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Days 1₩ 2□ F Months 94 212-18-7689 Director Nov 11 1906 Maryland Usual Rasidence of Decedent 10a Stata 10c. City. Town or Location 10b. County 10d. Insida City Limits 25a-f show Frederick Frederick Maryland 1 ☐ Yas 2 ☐ No Directo must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 8505 Edgewood Church Road 21702 USA 23a 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - Amarican Indian. Black, Whita, atc. 1 Yas 2 No
If Yas, Giva
Yaar or Datas: 72 hours after 1 ☐ Nevar Married 2 Married à 1 ☐ Yas 2 ☐ No Specify: Specify: White by 3 ☐ Wirdowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) should be filed within 7, and Mental Hygiene, r marked other than "ne Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Electric Relay Saltimore, Maryland 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Father's Nama (First, Middla, Last) William Thomas Grimes Idella Bell and a 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Pages 1 and 2 si ment of Health an Roscoe Meredith Grimes, Jr./son Mem 27 I 205 Monroe Avenue, Frederick, Maryland 21701 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata partment o important: if the any injury or 2003 1 ☐ Burial 2 Cremation 3 ☐ Removal from Stata Smithsburg Crematorium 12-11-00 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Entar tile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heapt failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Physician Immediata Causa (Final diseasa or condition rasulting in daath) /Medical Examiner Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequance of): Box 68760, Dua to (or as a consequence of) 189 BS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown signed by Division of Vitai Records, 9 funeral director, page 2 should be 24b. Ware autopsy findings available prior to complation of causa of death? Be Completed 24a. Was an autopsy hes 1 Yas 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 5 Rasidance 8 Othar (Specify) 1 Yas Certification: To this 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of 1 Natural 5 Pending s efter death. 1 ☐ Yas 2 ☐ No investigation 2 Accident 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicide within 24 hours To the Funeral I Hospital Medical 29a. Certifier Sertifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. iner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check only one) To the 29b. Signature, 29d. Data signed (Month, Day, Year)

State Registra 32. Registrar's Signatura



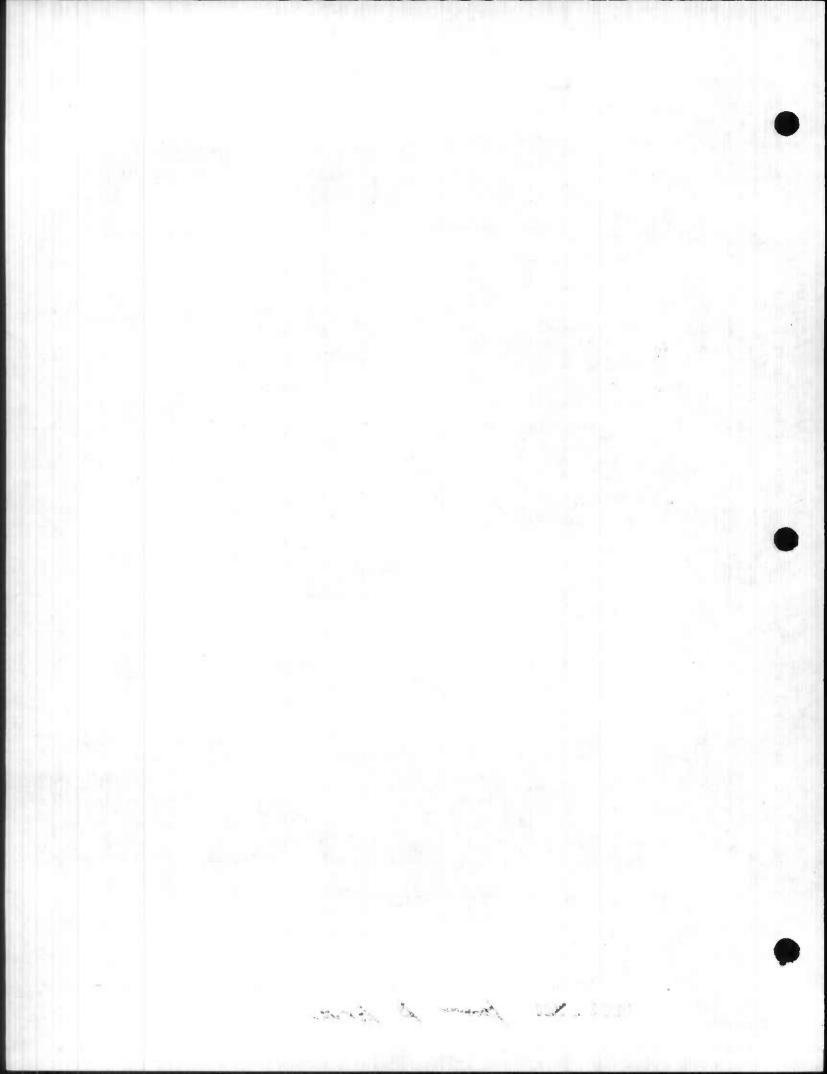
# permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health end Mental Hygiene. Name: Helen Virginia Hull Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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		State of Marylan		rit of Health		/giene () ()	42657			
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Funeral	5. Social Security Number 6. Sex	7. Aga (In yrs.	last birthday) If Und	er 1 Yaar   If Und		8. Data of Birth 9. Birthplaca (S				
Director	214-09-3706	M 2√F 87	Yrs.	Day's Hou	July :		Maryland			
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Jeath 23	12412 Big Spring I	12. Was Dacedent Evar in U	,S. 13. Was Dec		Origin? (Specify Yas or N can, Puarto Rican, atc.)		- Amarican Indian,			
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the de	Part II. Other significant conditions con	tributing to death but not ras	ulting in the underlying	causa given in Pa	art I. 23b. Di	d tobacco use cont	ribute to the cause of death?			
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To the Hospital or Attanding Physician: The is within 24 hours effer death.  To the Fureral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Cartifiar 1 Certifying Phys (Check only one)	and place, and due fo the	and place, and due fo the cause(s) end menner as stated.  eath occurred at tha time, data and plece, end due to tha cause(s)							
ompko the	29b. Signature and fittle of certified	and mannar sfafed.	2	9c. License numb	er	29d. Dafe signed	(Month, Day, Year)			
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	30. Name end eddress of person who con	1	n 23a) (Type Print)	U 3 &3	10					
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State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day Month Year Physician George F. 5 2000 ecember. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltmore
H Under 24 Hrs. 8. Date of 5. Social Security Number Ot Maryland 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Months Hours 10XM 2□ F Yrs. Director 419-14-6939 76 Alabama Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla neat of Health and Mentel Hygiene.
In the file marked other than "natural", or items 23a or 28a-f show into it them 27 is marked other than "natural", or other traumatic event, may be neutrical.
Into or other traumatic event, may be neutrical. 1 Yes 2 No Director Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Strafford Drive 21701 Funeral 811 E. 14. Race · American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc. 1 XYes 2 No
If Yes, Give
Year or Dates: 1942-46 1 Never Married 2 ☐ Married 21215-0020 1 Yes 2 No Specify. à 3. Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Drug Store Pharmacist aitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Richard Marion Hutto, Jr. Lena Belle McCrary 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Julie Hutto, daughter 3002 Black Rock Road, Myersville, MD 21773 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 12/9/ 1 Dariat 2 Cremetion 3 Removel from State permit. Page Department of Important: If eny Injury or page. 4 Donation 6 Other (Specify) Zion Lutheran Cemetery 2000 Middletown, Maryland 22. Name and Address of Facility 2). Signature of Funeral Service Monny Keeney and Basford Funeral Home M00999 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and shock, or heart failure. List only one cause on sach line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Subdura hemotomo disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner inlur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for this a consequence of Box 68760, Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying caulie area in Part I. P.0. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabeles mellitus, peripheral vascular disease Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? arten/disease Alzhelmer's disease Parkinson's disease, dementia, athalfionilation of Vital Attending Physicien: 25. Was case referred to medical examiner?

1 M Yes 2 No Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Naturat
2 Accident Division ie Hospital or Attending in 24 hours efter desth. he Funeral Director: Aft. pietaly filled in by the fur 1 Yes 2 No 11-23-00 unknown Fall downstairs in Wheelchair 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 200 E. 14th St myersvillemb Long term care facility Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stafed.

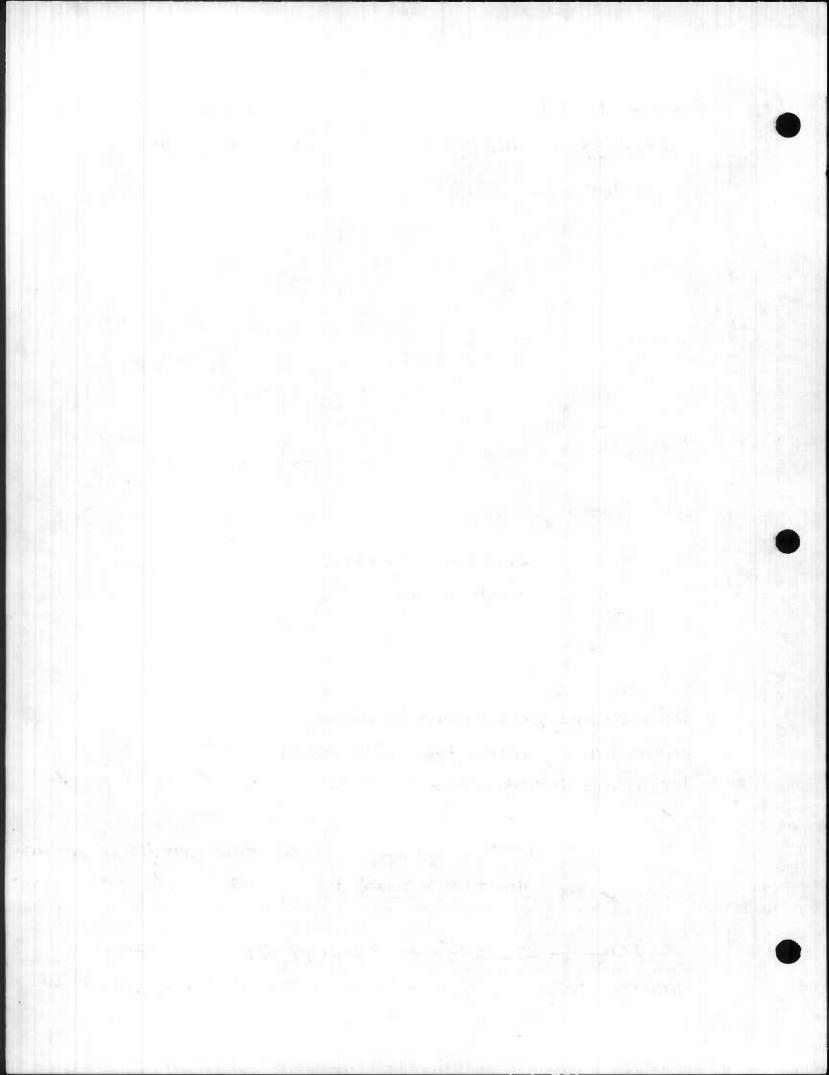
2 | Intedical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Battimore MD 21201 22 S. Greene McCupp Maurcen

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

DEC 0 8 2000

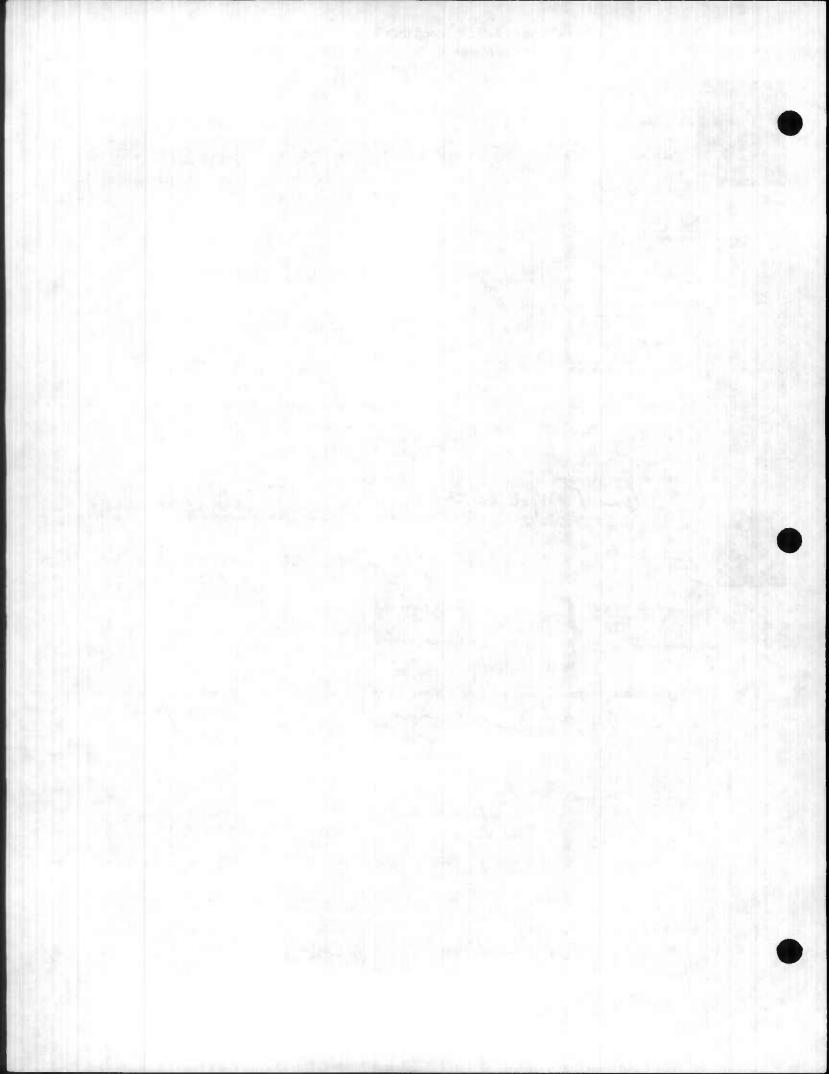
32. Registrer's Signature



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 42659

				C	ertificate of	Death		Reg. No.						
		1. Decedent's Neme (First, Middle, Las	st)				2. Data of De		3. Tima of Death					
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		5. Social Security Number 6. S		In yrs. last birthda	1 11 11 1 1 1 1 1 1	If Under 24	Hrs.   a Data of Bir	1						
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M Page II	So	12			Clerk			Court						
D STEE	89	17. Fethar's Name (First, Middle, Last)				18. Mothar's	s Name (First, Middla	, Maidan Sumama)						
Apply of the state	0	Walter S. Tho	mpson			Bes	sie M. H	Belt						
Maryland 42 should be lise in and Mental Hy 7 is marked othy traumatic event	1	19a. Informant's Neme/Ralationship (	Type, Print)	19b. Ma	iling Addrass (Straa	t and Number	or Rural Routa Numb	er, City or Town, Stata	, Zip Coda)					
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		Ullin L.	Mollowa	m 2	6401 Ridg	e Road	, Damascus	, Maryland	20872					
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Division Attendated after the Director:	=======================================	3 ☐ Suicide 6 ☐ Could not be determined	28a. Pieca of injury	- At homa, farm,	straat, factory, office		28f. Location	(Street and Number or wn, Stete)	Rural Routa Number,					
d page	Certification:	4 🗆 Houricide	building, atc. (	<i>эреспу)</i>			City of 10	WII, 51616/						
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DIVI To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai		niner: On the basis of ax	amination and/or										
within 2 To the comple	Z e	29b. Signature and title of certities	11		29c. Licen	se number		29d. Date signed (Mo	nth, Day, Year)					
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	V.S	30. Name and addrass of person who					D . 1	1/	1 0001/					
		Joel R. Schulman	l y L'L y L'		Georgetor	vn Koad	, Bethesda	a, Maryland	1 20814					
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( Amended item#10e FCHD KS 12/15/2000 Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month December 13 2000 **Physician** Margaret Elizabeth Hershberger 10:42am /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year)
Jan 2, 1920 5. Social Security Number 7. Aga (in yrs. last birthday) If Undar 1 Yaar Birthplaca (Stata or Foreign Country) 6 Sex **Funeral** 10 M 20 F Days Months 80 220-03-2362 Maryland Director Usual Rasidence of Dacedant Manyland 10a Stata 10d Insida City Limits 10b. Counts 10c. City. Town or Location 7 is marked other than "natural", or itema 23s or 28s-f ahow traumatic event, the Medical Examinar must be notified at Maryland Frederick Frederick 1 ☐ Yas 2 No Director the 8103 Canterbury Drive 10f. Zip Coda 10e. Street and Number 10g. Citizen of What Country? with 21704 U.S.A. 8103 Centerberry Drive Funerai deeth 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yas 220No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yas 2€ No Specify: White þ 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Nama (First, Middla, Maidan Sumama) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Nem 27 is marked other
any Injury or other traumatic event. 17. Fathar's Nama (First, Middla, Last) Be Smith Bessie Albert Dyer To 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 8734 Treasure Avenue, Walkersville, MD 21793 Ms Patsy Eavey, Niece 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Mt Olivet Cemetery Dec 16,2000 | Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatura of Funaral Sarvice Ligery 22. Nama and Addrass of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 \_ MO0706 disaasa 23a. Part Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical 10 cm Examiner Dua to (or as a consequence of) Physician/Medical Examiner certificate be executed igned by the attending physician end be detached for use as the burial-transit Sequentially list conditions, if any, leading to immadiate causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by 1 Yes 2 No 3 Probably 4 Unknown law requires that þ 24b. Wara autopsy findings available prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy Hospital or Attending Physician: The law 24 hours after death. Funeral Director: After this certificate has tiely filled in by the funeral director, page 2. 2 PNo 1 ☐ Yas 2 ☐ No 1 Yes Be 25. Was casa rafarred to medical 26. Place of Daath (Check only ona) axaminar? Hospital: 1 Yes 200 Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 10 1-Nonpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of Certification: 28c. injury at 28d. Dascribe how injury occurred 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and placa, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifier Medical completely (Check only 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifier DU9689 arr

State Registrar 31. Data filed (Month, Day, Year) 32. Registrar's Signatura DEC 1 5 2000

30. Nama and addrass of person who complated causa of daath (Itagr 23a) (Type, Print)

A. Austin Pearre,

Jr, M.D., 300 West Ninth Street, Frederick, Maryland 21701

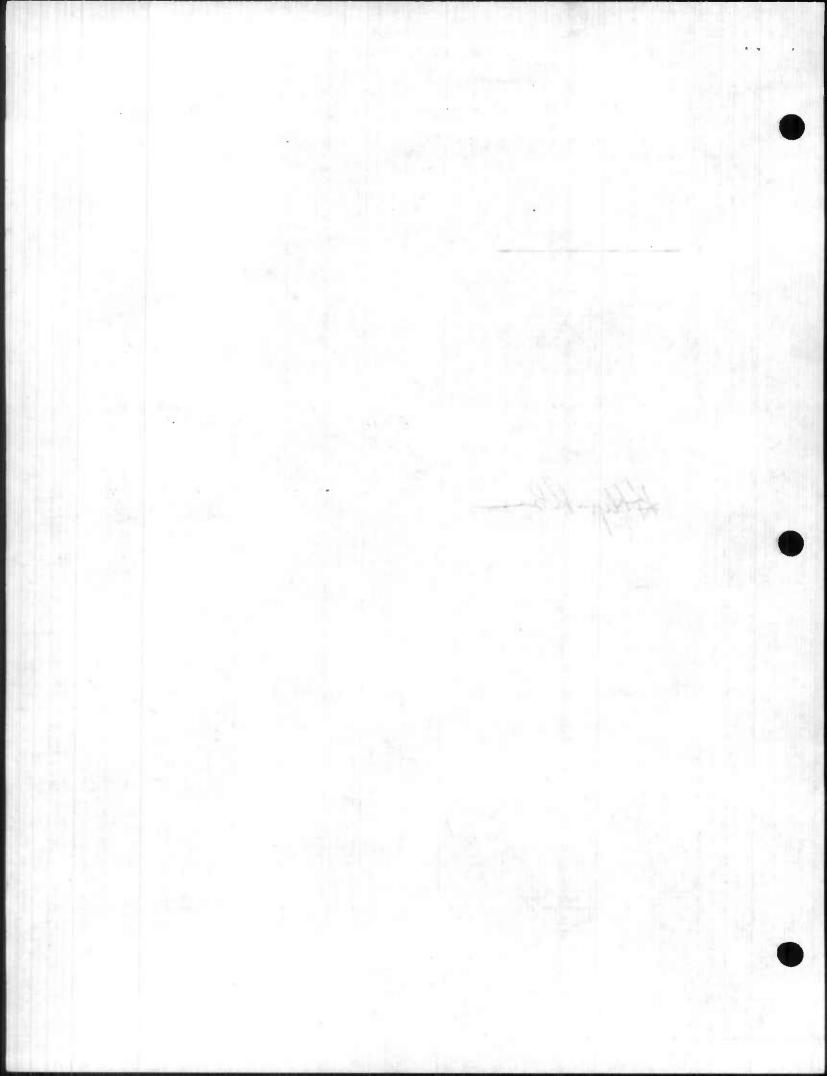
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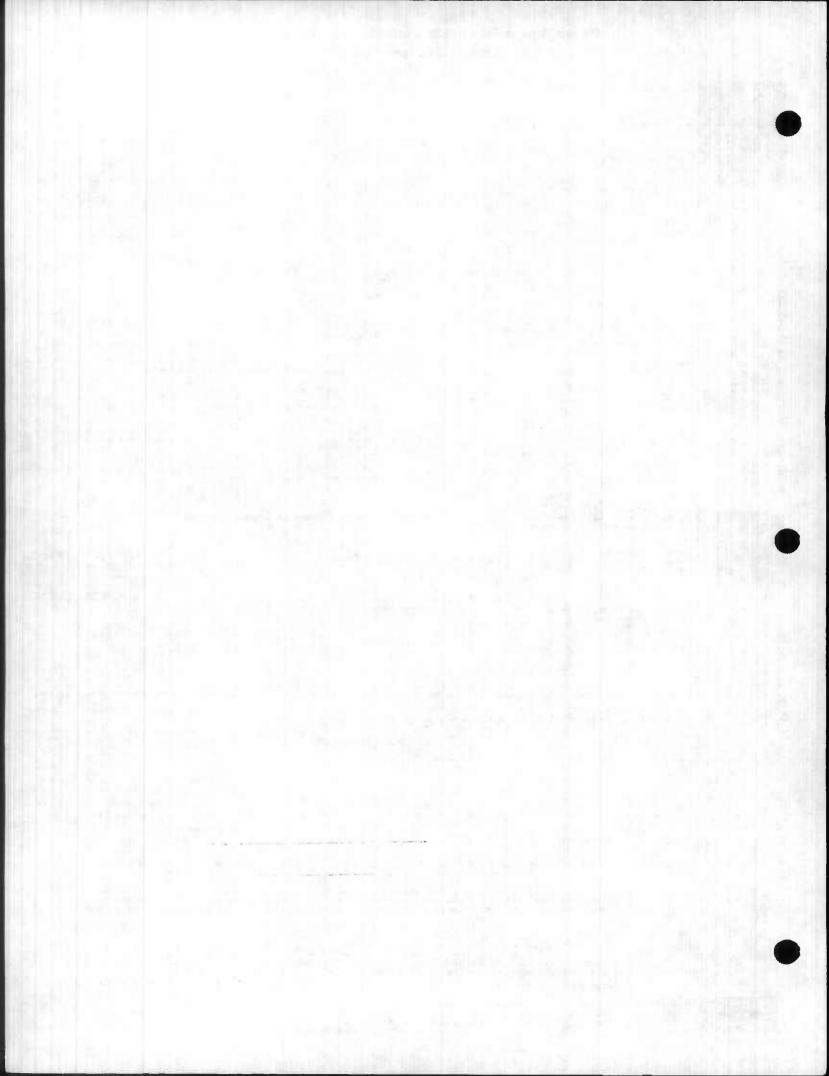


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State of Maryland / Department of Health and Mental Hygiene 0 4 2 6 6 1

Certificate of Death

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4	1. Decedent's Neme (First, Middle,	Last)							2. Dete of De Month	eath Day	Yeer	3. Time of Death	1
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ylar ould b Menti	William Smith						Ann	a S	tearn				
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and 2	Margaret Stepher	ns / Daugl	hter	14813	Flin	itst	one L	ane.	Silve:	Spring	. Mar	ryland 20	905
other 1	20a. Method of Disposition		own, Stete	, ,									
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altimore mil. Pages 1- partment of He portant: if then y injury or oth ES.	4 Donetion 5 Other (Spe		Gat	e of I								ng, Maryl	and
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of Vital Records, Physician: The lew requires the this certificate has been signeral director, page 2 should be a factor. To Be Completed by:	25. Wes case referred to medical examiner?	11				10			th (Check only				
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ding Ph h. After thi funeral	27. Menner of Death	28a. Date of	f fnjury n, Day Year)	28b. Time of	1 2	8c. fnje We	ury et ork?		28d. Describe	how Injury occur	rred		
ion ndin	2 Accident investige		, , , , ,		M		Yes 2	No					
Division or Attending I after deeth. Director: After I in by the fune ertification	3 Suicide 6 Could no determin	208. Place	of fnjury - At ho	me, farm, str	eet, factor	y, office					ber or Au	ral Route Number,	
Division of standing P is after death.  al Director: After ted in by the funerication:	4 Homicide	buildin	g, etc. (Specif)	")					City or 10	own, Stete)			
Surs Surs	29a. Certifier 1/3 Certifying	Physician: To the b	neet of my know	uladoa daath	occurred	et the t	ime date su	and place	and due to the	causa(s) and m	annar as	etated	
Divisio To the Hospital or Attendid within 24 hours after deeth. To the Funeral Director: A completely filled in by the fu	(Check only 2 Medical En	caminer: On the bes	sis of examinet	lon end/or inv	vestigetion	, in my	oplnion, de	eth occur	red et the time	, date end plece,	and due	to the ceuse(s)	
The mple	-	and menn	er steteo.	-	20	Lines	se number	-		29d. Date signe	nd /Month	Day Veer	
S. S. S. S. S. S. S. S. S. S. S. S. S. S	29b. Signature and title of certifier				290					_			
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	30. Neme end eddress of person w				Print)		13		_	b		A 1	
	SAERA	ZAID	1	801	TOU		LOUVS	SE	Ave	red	enc	u. Mg	
State	31. Date filed (Month, Day, Year)		gistrar's Signa				Type I						
Registrar	DEC 1	8 2000 b	here	4	6	1							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Russell December 20, 2000 Zimmerman Horman 0650 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick | Tunder 24 Hrs. | 8. Date of Birth | Hours | Min. | (Month, Day Year) | 1908 5. Social Sacurity Number If Undar 1 Yaar 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Months Days 217-10-9609 92 Yrs. Director Uaual Residence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Frederick Frederick items 23a or 28a-f the Medical Examiner must be notifi-10e. Street and Number 5109 Cap Stine Road 10f. Zip Code 10g. Citizan of What Country? 21703 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Americen Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Yaar or Datas: 1 Never Married 2 Married à Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White Àq 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Buainess/Industry should be filed within al Hygiane. Elamentary/Secondary (0-12) Collega (1-4or 5+) Real Estate Agent Real Estate 17. Fsthar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) is marked of George Washington Horman Mary Zimmerman 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 an Department of Health and Important: If New 27 is in any Injury or other traum office. 5109 Cap Stine Road, Frederick, Maryland 21703 Virginia Thomas Horman/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cramation 3 Removal from Stata
4 Donation 5 Other (Specify) Entombment Mt. Olivet Mausoleum Dec. 22, 2000 Frederick, Md. 22. Nama and Addrass of Facility Keeney and Basford Funeral Home M00021 106 East Church Street, Frederick, Md. 21701 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or haart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical neumonio Examiner Due to (or as a consequence of): Physician/Medical Examiner The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disease or injury Due to (or as a consequence of) Box 68760. that initiated events resulting in death) Last Dua to (or as a consequence of): of Vital Records, P.O. Part il. Other significant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown yd bengis 4-11 tuc Medical Certification: To Be Completed by page 2 should be 24a. Was an autopsy 24b. Were autopsy findinga available prior to completion of cause of death? certificate hes 1 Yes 200 1 Yea 2 No in or Attending Physician; The safer death.

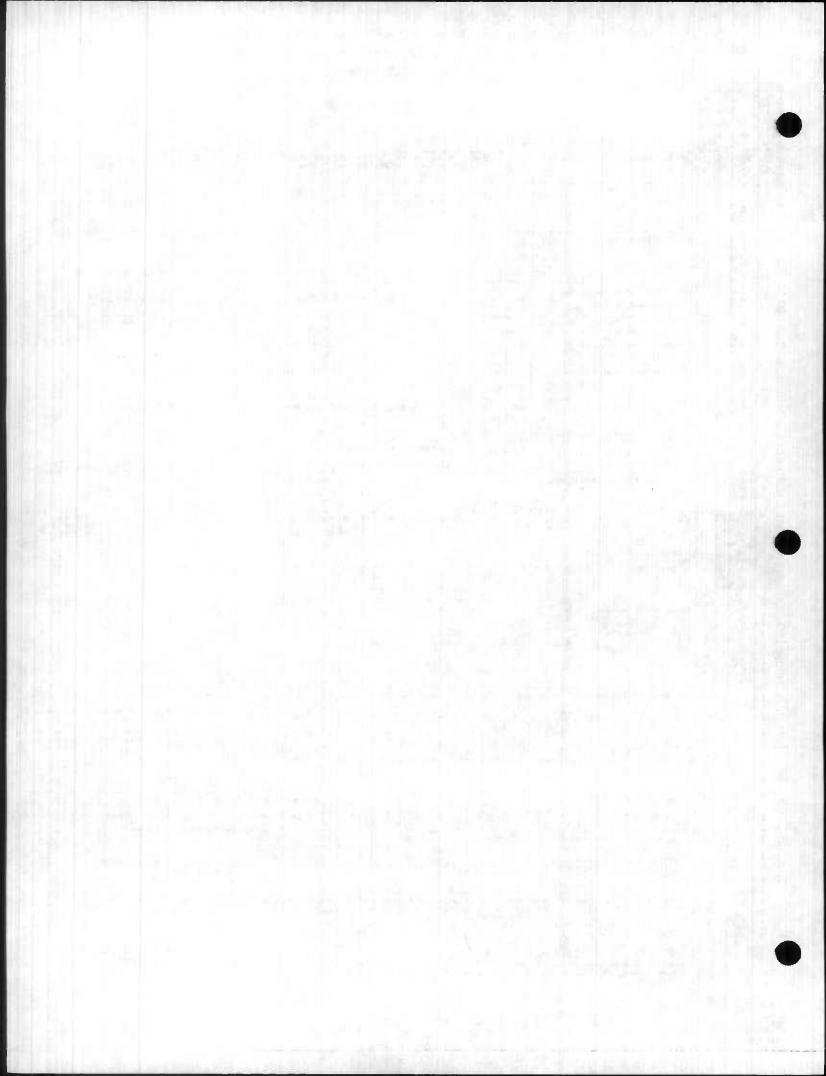
In Director; After this certificate ed in by the funeral director, pa 25. Was case referred to medice! axaminar? 26. Place of Death (Check only ona) Hospital: 1 Impatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred fnjury at Work? Division 5 Pending investigation Watural 1 Yea 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) yd ni bellii 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a Cartifier Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mannar stated 29b. Signature and the of certifier 29c. License number 29d Date signed (Month, Day, Year) D16428 30. Name and addless of person who completed ceuse of death (item 23e) (Type, Print) Casper E. Cline, III, M.D. 300 W Ninth Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) DEC 2 2 2000 32. Registrar's Signatura State

DHMH 16 Rev 6/95

Registrar

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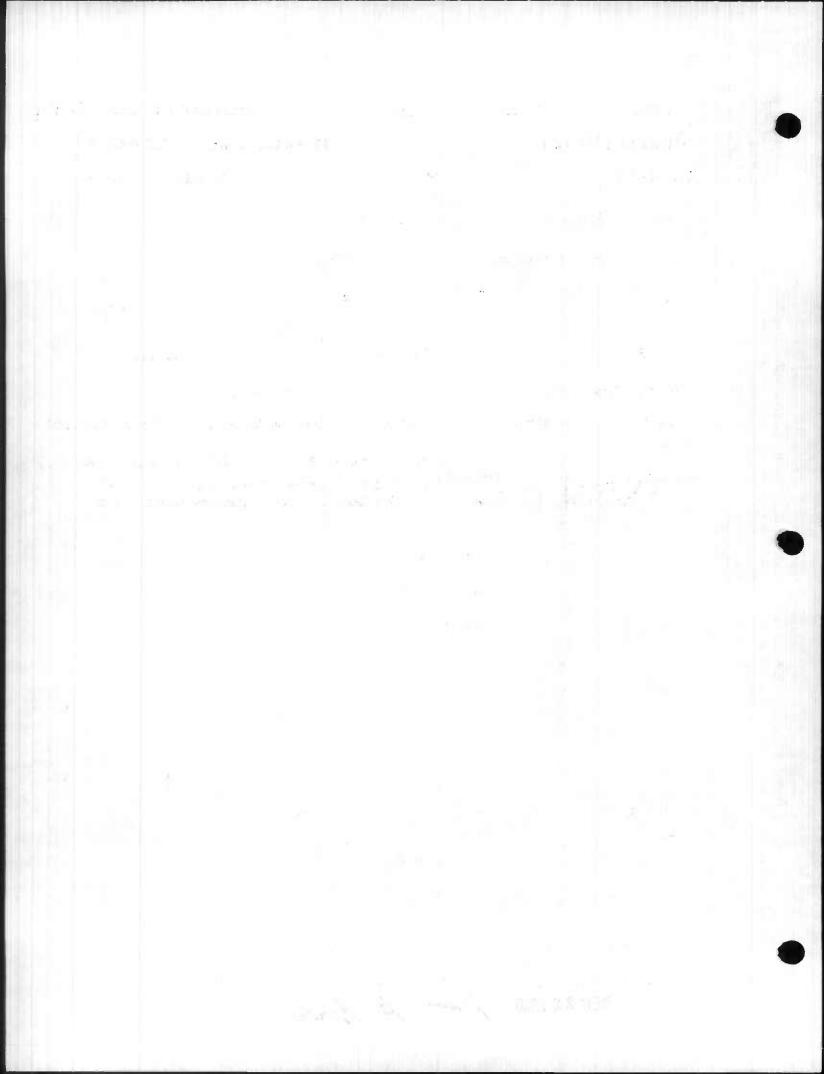
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State of Maryland / Department of Health and Mental Hygiene 2 4 2 6 6 3

					Certificate	of Death	Reg	g. No.		
		1. Decedent's Name (First, Middle	, Last)	1200			2. Data of Death Month		/ear	3. Tima of Death
6	Physician /Medical	CATHERINE	JOHNSON		JACKSON		DECEMBE	R 21,20	OO	2:25 AM
10	Examiner	4a Facility Name (If not Institution	, give street and number)			4b. City, Town, or Lo	cation of Death	4c. County of	Death	
2		ATLANTIC GENER	AL HOSPITAL			BERLIN		WORC:	ESTE	R
1-6	Funeral Director	5. Social Security Number 579–28–0435		(In yrs. last birt 92	hday) If Under 1 Y	faar If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, June 14	(1,1908)	Birthpia Countr Mar	ace (State or Foreign ry) ryland
00	2 .	Usuat Residence of Decedent  10a. State 10b. County	1	IOc. City, Town	or Location				10	ed incide City Limits
1	anyla ashon ad at		omico		sbury				10	d. inside City Limits  X□ Yes 2□ No
0	or 28e-f s be notified Director	10e. Street and Number	MICO	Daii	10f. Zip Co	46	10	g. Citizen of Wh	ot Count	
(0)	S	718 S. Park D	rive			21804		USA		
0200	curs after death vest, or items 23 Examiner must	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Ev. Armed Forces?  1 □ Yas ※ No If Yes, Give Year or Dates:			of Hispanic Origin? (Sp. Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race- Black, Specify:	White, e	
300	72 h	15. Decedent (Specify only highes		16a.	Decedent's Usual O (Give kind of work d	ccupation lone during most of work etired)	ing 1	6b. Kind of Busi	ness/Indo	ustry
202	ed within 72 ho ygene. er than "natur 4, the Medical.	Elementary/Secondary (0-12)	Coilege (1-4or 5+)			etired)		Dobai	3	
2000		12 17. Father's Name (First, Middle, I	l act)	5	ales	18. Mother's Name	/First Middle M	Retai.		
4 Can	ad off	J. Kirwan Ha				Abigai		Johns		
300	A Man d Man d Man metho To	19a. tnformant's Name/Relationsh		19h	Mailing Address (S)	treet and Number or Run				Coda)
- 2	or the second	Dr. Robert T. A				t Creek Ct.				
585	Heat Heat Other	20a. Method of Disposition	CALLINO, DOIL TH	20b. Place of	Disposition (Name of	of		Oc. Location - C		
S King	Page iment of tant: It?	1 🗀 Suriai 2 🗆 Cremation 4 🗆 Donation 5 🗆 Other (Sp	pecity)		y, cramatory or other Memorial	Park ]	2/22/00	Salis	_	
Bal	Departiment any in	21. Signature of Funeral Service I	6 Oliva	_	Hollowa 501 Sno	ddress of Facility Y Funeral H W Hill Rd.,	ome Prof Salisbu	essiona ry, MD	1 As: 2180	sociation 4
		20a. Part1. Enter the disease, or hock, or heart failure. List	complications that caused the	daath. Do n	not enter the mode of	f dying, such as cardiac	or respiratory arre	st,	1	Approximate Interval Between
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	/Medical	immediate Cause (Final disaasa or condition	DNC	ume	NIA				0	days
	Examiner	resulting in death)			consequence of):	100			1	
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	ifficate be executed g physician and as the bunal-transit	Sequentially list conditions,	Dr.	ue to (or as a c	consequence of):					NEED E
68760,	ician and ician and burial-tran	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events	c							
785	physicies to physicies the but	that initiated events resulting in death) Last	Du	ue to (or as a c	consequence of):				1	
			d							
Вох	attending for use as						Lian arrest			
P.O.	at the death cert d by the attendin seteched for use Physician/N	Part ii. Other eignificant conditio	ne contributing to death but	not resulting in	the underlying caus	se given in Part i.				the cause of death?  ably 4 Unknown
	igned by the detection by Phy						10 10	s ZLFNO	Prob	abiy 4 Olikilowii
Division of Vital Records,	The law requires that the death certained has been signed by the attendir page 2 should be detached for use Completed by PhysicianA						24a. Was an perform	autopsy ed?	ava	re autopsy findings iliable prior to npietion of cause leath?
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\frac{1}{2}	ysician: is certific director,	25. Was case referred to medical examiner?	Hospital:			Other:	h (Check only one			
o	Physic chis carel dire	1 Yes 2 No	1 Pinpatient			4 LI Nursing Ho	me 5 Resider		1.4	")
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3	deat ctor: y the	3 Suicide 6 Could r	not be 28e. Place of injury	y - At home, fa	rm, street, factory, of	ffice	28f. Location (Str.		r or Rurai	Route Number,
Ş	tal or Attending Piss after death.  Solution of the funeral of in by the funeral of the funeral certification:	4 Homicide	building, etc.	(Specify)			City or Town,	State)		
	To the Hospital or Attending Physician: Whith 24 hours after death To the Funeral Director: After completely filled in by the funeral director, Medical Certification: To Be (		g Physician: To the best of e Examiner: On the basis of e and manner state	xamination and						
	Me Me	29b. Signature and title of Certifier			29c. L	icense number	29	d. Date signed	(Month, I	Day, Year)
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	4	30 Name and address of nerson		(2) hth (itam 23a) (	Type Print)	1700	10	7/01/		
	Da	30. Name and address of person	DICKI	(nam 20a) (	D	Bo. Co	ms			
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State of Maryland / Department of Health and Mental Hygiene 142664

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iner	20	f not institution, giv	e street end number	)			4	b. City, To	wn, or Lo	ocation of Deat		inty of Deeth		
	Manoki	in Illano	DY						cess	Anne		omer	set	
al	5. Social Security N	1	ex 7. A □M 2 <b>1</b> □F	ge (In yrs. I	lest birthday)	If Unde Months	or 1 Year Deys	if Under Hours	24 Hrs. Min.	8. Dete of Bit (Month, De	th ey, Yeer)	9. Birthp	lece (Stete o	r Foreig
or	219-05-33 Usual Residence of	75	o		84 Yrs.					5/7/1	916		land	
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0	MD	Somerse	et	Pri	incess	Anne	2						1 □ Yes	
Funeral Director	10e. Street end Nur	N. SHIPPIES		~ 5.	LITECOD		ip Code				10a Citizen	of Whet Coun	tn/2	
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era	11974 11. Maritel Status	Edgehill	12. Was Decedent	Ever in U	S 13 V	Vas Dec	2185		ioin? (Sp	acify Yes or No		SA Rece - Americ	an Indien	
Fur		ied 2□ Merried	Armed Forces	?	If	Yes, sp	ecify Cube	n, Mexicen	. Puerto	ecity Yes or No Rican, etc.)		Bleck, White,		
by	3 Widowed		If Yes, Give Year or Detes:		1	☐ Yes	2 X No	Specify:			Spe	ecity: Whi	to	
fed		15. Decedent's Ed	lucation		16e. Deced	ent's Us	ual Occup	etion			16b. Kind o	f Business/Inc		-
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ToE	George	Henry Har	rdv					Mah	ole G	rav				
-		me/Reletionship (			19b. Mailin	g Addres	s (Street			el Route Numb	er, City or To	wn, State, Zip	Code)	
	Ruby Rig	gin (dau	ghter)		180	9 We	est C	lear	Lank	e Dr.,	Salis	ourv, N	ID 218	04
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and a	114	01191	In	0,00	HC					ome, P.				
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cati	2 Accident	Investigation				М		Yes 2 🗆	No					
Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Plece of In building, e	jury - At ho tc. (Specify	me, farm, stre	et, facto	ry, office			28f. Location ( City or To		imber or Rure	Route Num	ber,
0														
		16 Certifying Phy	ysician: To the best niner: On the besis of	of my know	viedge, deeth	occurred	d et the tim	ne, date en	d plece,	end due to the	cause(s) end	manner es st	eted. the ceuse(s	)
	29a. Certifier (Check only	2 Medical Exam	end manner st	eted.										
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	(Check only one) 29b. Signeture end	title of certifier				29	c. License						Joy, roar,	
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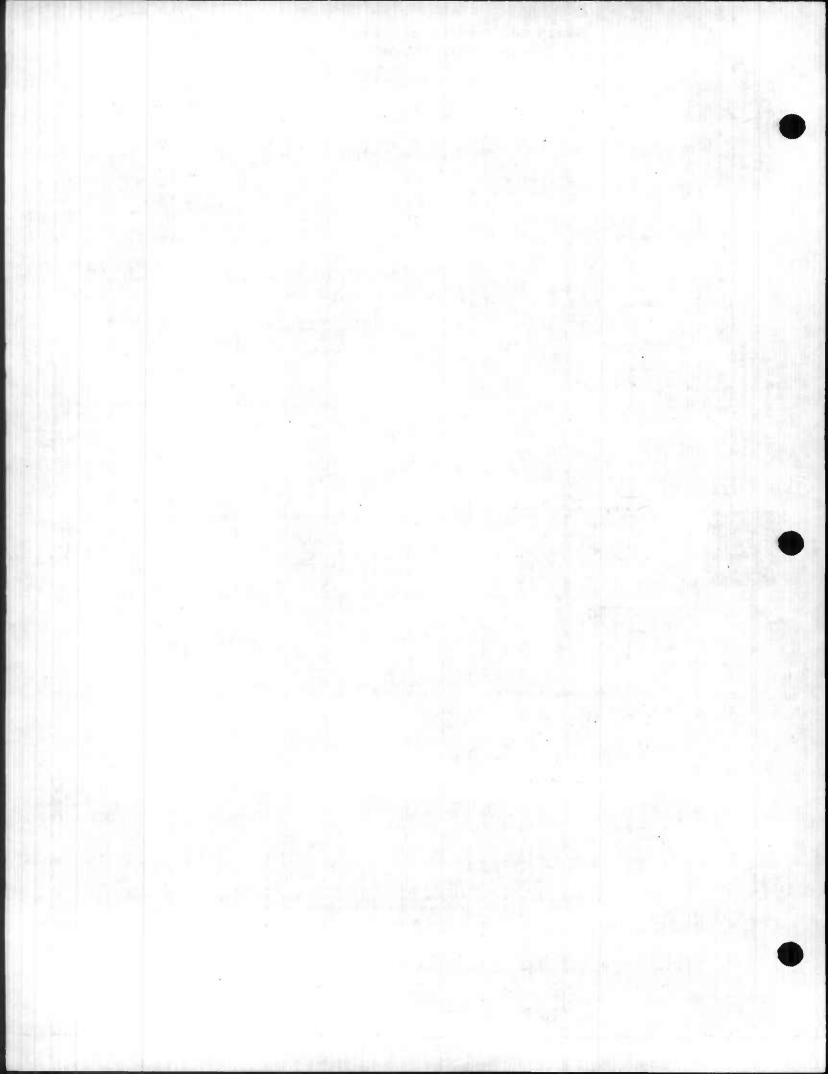


Dorothy Johnston

			,,,,,		". (	Cert	ificate	of	Death			Reg. N	No.	7 6.	.000
Di di i		1. Decedent's Neme (First, Middle	, Last)	- 7							2. Date of D		Day	Year	3. Time of Death
Physicia /Medica	_	DOROTHY G.	JOHNSTON								Decemb			2000	0750
Examine	_	4e Facility Neme (If not institution	, give street end r	rum <i>ber)</i>					4b. City, To	own, or L	ocation of Dee	ith 4	c. County	of Death	
		The Memorial	Hospi	tal	23.5			E	asto	n			ralb		
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 <b>X</b> ☐ F		In yrs. lest birth		If Under 1	Year Days	Hours Hours	Min.	8. Date of B (Month, L APRIL	irth Dey, Yea	ir)	9. Birthp	place (State or Foreig ntry)
Director	-	212-24-3694	10 m 201		/1 Yı	S.					APRIL	29,	1929	MD	
pus *	1	Usuet Residence of Decedent  10a, State  10b, County		1	0c. City, Town	or Loca	ition			-				Ţ,	10d. tnslde City Limits
/ahc	6	MD CAROI	TME		DID	י דידר	17								1 XYes 2 No
the t	Director	10e. Street and Number	TINE		RID	JEL.	10f. Zlp (	Code	-	-		100. (	Citizen of V	Whet Cou	ntry?
sth with the Menylan 23a or 28e-f show		211 MAPLE AVE						166	.0				USA		,
0036 hours effer deeth with the Meryland ural; or flems 23s or 28s-f show	Funeral	11. Meritet Stetus	12. Wes De	ecedent Eve	er in U,S.	13. Wa				rigin? (St	pecify Yes or N	10-		e - Ameri	can Indien,
fler des	F	1 ☐ Never Merried 2 ☐ Marr	Armed ied 1 ☐ Ye	Forces?							pecify Yes or No Rican, etc.)			ck, White,	
036 urs ef	p	3 ☐ Widowed 4 ☑ Divorced	If Yes, t	Give		10	□Yes 2	[][No	Specify	:			Specify	WHI'	TE
15-003	Completed	15. Decedent		-40	16a. C	ecede	nt's Usuet	Occup	ation	. 4 4	le lan ac	16b.	Kind of B	usiness/In	dustry
vithin 72 hours of ene.	ple	(Specify only highes Elementery/Secondary (0-12)	1	(1-4or 5+)		ite. Do	NOT use	retire	during mod d)	SI OF WOR	(III)	EL	ECTRO	NIC	
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and 2 be filed of other event, p	Be	17. Fether's Neme (First, Middle,	Last)								e (First, Middl	e, Maid	en Sumen	10)	
arylan should be nd Mental marked o	0	HARRY NUSBAUM					100		IDA	MAR'	rin				
0 0 0		19e. Informent's Neme/Reletions	nip (Type, Print)		19b. I	Meiling	Address	(Street	and Numb	er or Ru	rel Route Num	ber, Cit	y or Town,	State, Zip	p Code)
2 2 2 2 2	-	TAMMA L. MATHIS	3						., R.	IDGE:	LY MD 2	¥			
0 8022		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion	3 ☐Removet from		20b. Plece of E cemetery,	creme	tion (ivem	e or her ple	ce)		Dete	20c.	Location -	City or To	own, Stete
		4 Donation 5 Other (S)			GREENM	'NUC	T CEM	ETE	RY		12-23-0	0	HILLS	BORO	, MD
Baltimo pemit. Pege Department o Important: If i any Injury or		21. Signature of Funeret Service	Licensee			FE.	LLOWS	Addre	ss of Facil	BEI	N & NEW	NAM	FUNE	RAL	HOME PA
40589		JOHN R.	MERCE	ERON	J CFSi	>20	0 S.	HAF	RRISO	Y ST	EASTON	, M	D 216	01	
		23e. Pert1. Enter the diseese, or shock, or heart feiture. List	complications the	t ceused the	e deeth. Do no	t enter	the mode	of dyin	ng, such e	s cerdiac	or respiretory	errest,			Approximete Intervet Between
Physician	1			,			-	1	gloit.						Onset and Death
/Medical Examiner		tmmedlete Cause (Final disease or condition resulting In deeth)		Lesp	1/4011	4	1-0	acl	NO.	2			.01	1	2/8 40
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D 15.	E I		b	COL	spret		Va	200	210	1	1166	cd			1 week
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DHMH 16 Rev 6/95

**ORIGINAL** 



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 42666 Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death Month **Physician** Dec. 19 2000 7:45 pm Marion Louise Jull /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, giva street and number) 4c. County of Deeth **Examiner** Glasgow Nursing Home Cambridge
If Under 1 Year | If Under 24 Hrs. | Dorchester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplaca (Stefa or Foraign Country) **Funeral** Days Hours 1□M 20 F Yrs. Director 99 <del>213-42-8710</del> July 29 1901 Canada Usual Rasidence of Decedant 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 XYes 2 □ No Director MD Dorchester Cambridge 94 10e, Street and Number 10f. Zip Coda 10g. Citizen of What Country? with "natural", or lierus 23a 311 Glenburn Avenue 21613 U.S.A. Funeral 13. Was Decedant of Hispenic Origin? (Specify Yas or No If Yas, specify Cuben, Maxicen, Puarto Rican, etc.) 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - American Indien, Black, White, atc. 1 ☐ Yas 2 🛣 No If Yas, Giva 1 ☐ Never Merried 2 ☐ Married Maryland 21215-0020 1 Yas 2 No Specify: à Specify: white It Yas, Giva Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry filed within Hygiene. other then Etamantary/Secondery (0-12) College (1-4or 5+) hospital dietician 17. Father's Nema (First, Middla, Last) 18. Mothar's Nema (First, Middle, Maidan Surnama) Be 2 should be in and Mental I Edna Mae MacDonald 2 Edward Monkley 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Steta, Zip Coda) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is re any injury or other traum P. O. Box 147, Hillsboro, MD 21641 Judy S. Jull-daughter in law Baltimore. 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removal from State Fort Lincoln Cemetery 12-26 Brentwood, Maryland 4 Donation 5 Othar (Specify) 21. Signature of Funeral Sarvice Licensee 22. Nama and Addrass of Facility Thomas Funeral Home, PA 700 Locust St., Cambridge, MD mApproximata Intarval Batween Onset and Death 23a. Part (Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final diseese or condition resulting in death) Examiner Dua to (or as a consaguance of) Examiner 24/1 unen Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last and Dua to (or as a consequance of): the attending physician 68760 8 Physician/Medicai as the Dua to for as e consequence of Box 0.0 Part II. Other significant conditions contributing to death but not rasulting in the undarlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2No 3 Probably 4 Unknown ð Division of Vital Records, 24b. Wara autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy Completed performed? hes page 2 2 No 1 Yas 1 Yes 2 No after death.

Director: After this certifications 25. Was cesa raférred to medice! Be 26. Pleca of Death (Check only ona) Other: A Nursing Homa 5 Residence 6 Other (Specify) Hospitet: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 70 28a. Data of tnjury (Month, Day Year) 28c. Injury et Work? 27. Mannar of Deeth 28b. Tima of 28d. Describe how injury occurred Certification: 5 Pending Invastigation Injury 1 Natural 1 Yas 2 No 2 Accident 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homlcide To the Hospital within 24 hours a To the Funeral D The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 004024 00

Registrar

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30. Nama and addrass of person

31. Data filed (Month, Day, Year)

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30 E. Dover St.

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Easton, MD

of death (Itam 23a) (Type, Print)

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\$2. Registrer's Signature

DEC 2 2 2000 Journey January

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 42667 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year KELLY MARY 425 C DEC 28 2000 4e Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth COLUMB1A HOWARD COUNTY GENERAL HOSPITAL HOWARD 7. Aga (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplaca (State or Foreign Country) 1 M 2 F Months Deys Hours 306-20-1563 76 Aug. 6, 1924 Wisconsin Usuel Residence of Decedent 10a Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2X No Florida Hillsborough Tampa 10e. Streel and Number 10f. Zip Code 10g. Citizen of Whet Country? 4312 B. North A. Street 33609 United States 11. Maritel Sletus 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, atc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Navar Marriad 2K Marriad 1□ Yes 2No Specify: Specify: 3 Widowad 4 Divorcad white 16e. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4 Teacher Education 17. Fether's Neme (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumema) Joseph Reppen Aurelia Morrissey 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4312 B. North A. Street Tampa, Florida 33609 James Kelly / spouse 20b. Plece of Disposition (Neme of cematery, cremetory or other plece) 20a. Method of Disposition Dec. 29 20c. Location - City or Town, Stete 1 ☐ Burial 2X Cremetion 3 ☐ Removal from State Metro Crematory 2000 Catonsville, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. 21. Signeture of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD. 21043 MOIOGL 23a. Pert1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aech line. Approximete Interval Between Onset end Death Immediate Ceuse (Final disaese or condition resulting in deeth) LIVER 48 HRG FAILURE Due to (or as e consequence of) Sequentietly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last Due to (or es a consequence of): Due to (or as e consequança of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uas contribute to the causs of death? 1 Yss 2 No 3 Probably 4 Unknown RENAL FAILURE 24b. Were autopsy tindings available prior to completion of ceuse of deeth? 24a. Wes en eutopsy RESPIRATORY PAILURE 1 Yes 2 No 1□ Yes 2 No 25. Was case referred to medicel axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No

**Physician** /Medical Examiner

**Physician** 

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permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Horsel Experience

Baltimore, Maryland 21215-0020

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1 Naturel

2 Accident

3 Suicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the tima, data end place, end due to the cause(s) end manner stated.

5 Pending

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6 Could not be

30. Nema end address of person who completed ceuse of deeth (Item 23e) (Type, Print) 10724 MD

28e. Date of Injury (Month, Dey Year)

PATHYENT PILWY

28c. Injury at Work?

29c. Licanse number

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1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

DEC. 28, 2000

MD

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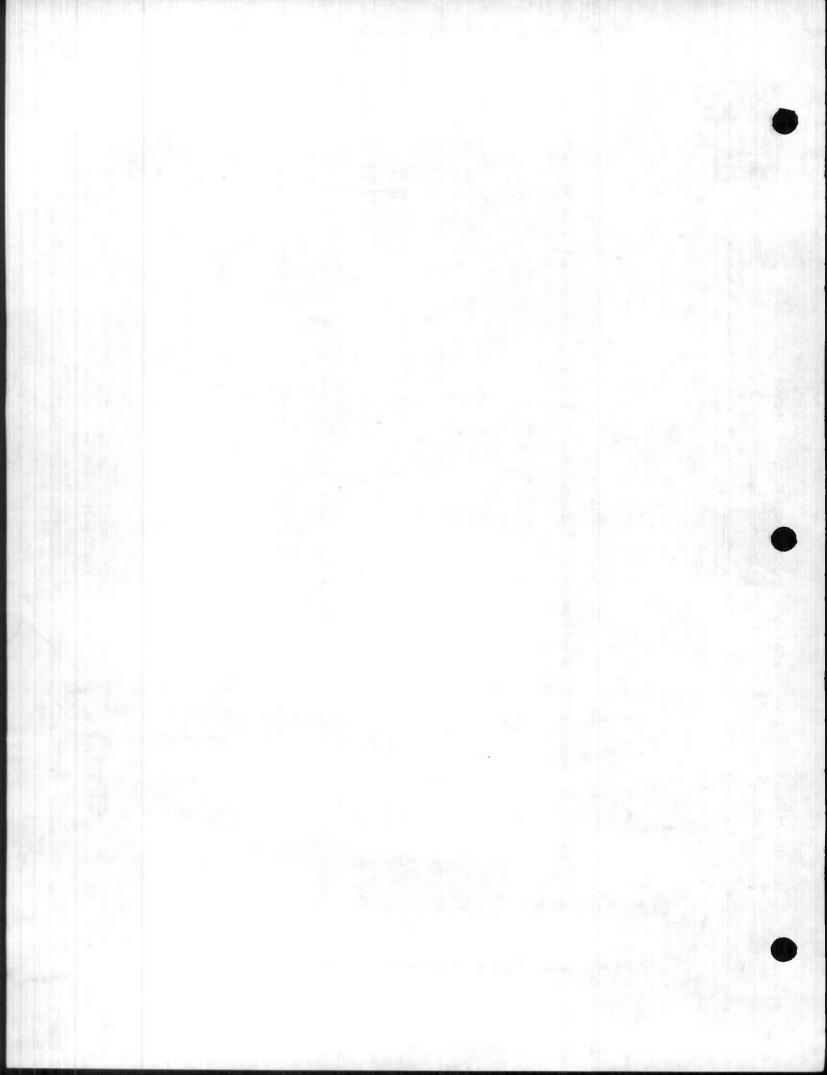
HTTLE 22. Registrer's Signeture

1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify)

28b. Time of

ALGKANDER 31. Dete filed (Month, Dey, Yeer) JAN 0 2 2001 Registrar



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death DEC. 27, 2000 2:13 P.M. LOUISE GALLAHAN KENLON 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Deeth 8730 MARSHALL CORNER ROAD POMFRET CHARLES 7. Age (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs. 8. Dete of Birth Month Days Hours Min. Month Day, Year) 9 1 Yrs. Month Days Hours NOV • 23, 1909 5. Social Security Number 9. Birthplace (Stete or Foraign 10 M 20 F MARYLAND 216-50-9665 Usual Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits CLINTON 1 Yes 2 No PRINCE GEORGES MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20735 12215 PISCATAWAY ROAD 14. Raca - Amarican Indien, Black, Whita, atc. 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Yes 2 No If Yas, Giva Year or Datas: 1 ☐ Nevar Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: WHITE 3. Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Collega (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maidan Sumama) JOHN HENRY GALLAHAN LULA BRANDT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) POMFRET, MD. 20675 8730 MARSHALL CORNER RD. ELIZABETH COOMBS-DAUGHTER 20b. Placa of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Removal from Stata ST.MARY'S CEMETERY 12-29-00 PISCATAWAY, MARYLAND 4 □Donation 5 □Othar (Specify) 22. Nama and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 LA PLATA, MARYLAND 23a. Pert1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwo Onset and Death Heart Failure Congestive Immediata Causa (Final diseese or condition resulting in death) you Due to (or as a consequence of) Dua to (or es e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown ural Vascul 24a. Was an eutopsy

**Physician** /Medical Examiner

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Medical Certification: To

The law requires that the death certificate be executed

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28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 Natural 1 Yas 2 No 2 Accidant 3 ☐ Suicide

6 Could not be determined 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, tarm, straat, tactory, office building, atc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) end mennar stated. 29a. Cartifiar (Check only

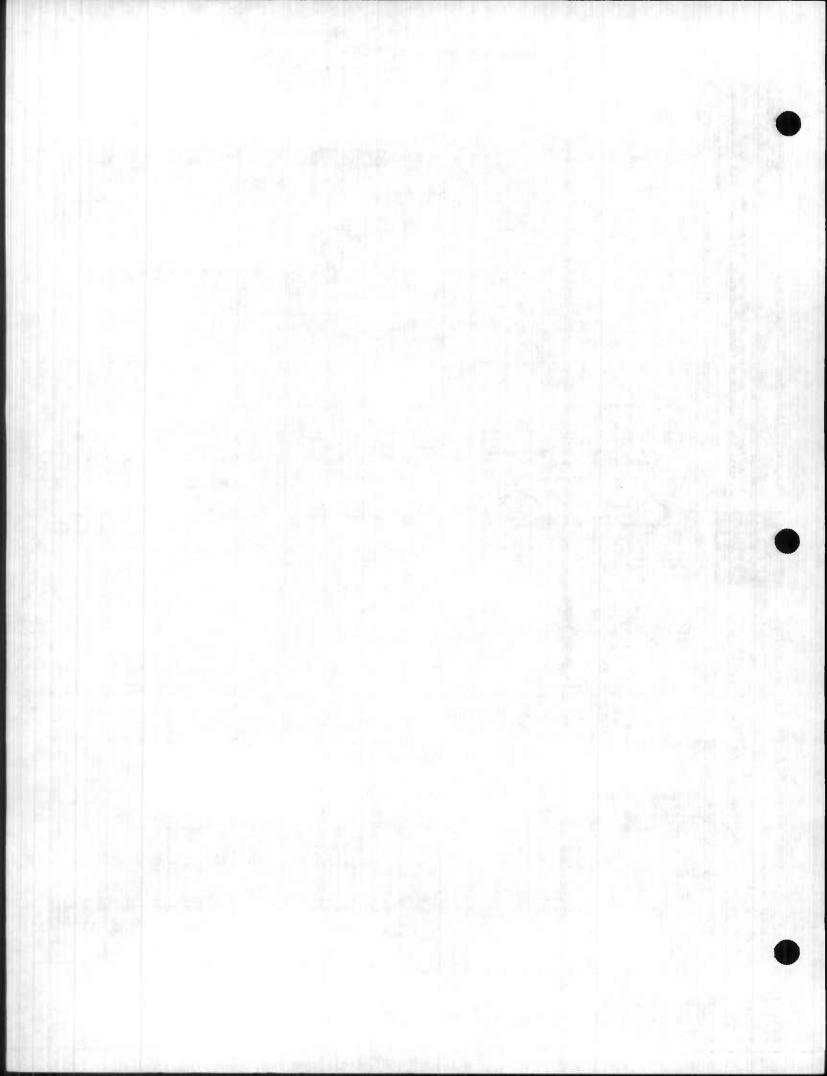
29c. Licensa number 29d. Deta signed (Month, Day, Year) 29b. Signatura end titla of certifier MD 12 28 2000

3600 Leonardtown Rd, WALDORF, MD 20601 30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print) VIVEK NAG MD

State Registrar

32. Registrar's Signatura DEC 2 8 2000

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Des Year 529 pm Donald Eugene King Dec 2000 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Washington County Hospital Hagerstown Washington If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10 M 20 F Days Months 179-12-5750 78 Rock Forge, MD Mar 8, 1922 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No PA Franklin Waynesboro 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 13650 Harbaugh Church RD 17268 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Black, White, etc. No 1941/ If Yes, Give Year or Dates: 1946 1 Never Married 2 Merried 1□ Yes 2□ No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Supervisor Truck Mfg 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Harry W. King Ethel M. Robinson 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma C. King Wife 13650 Harbaugh Church RD Waynesboro PA 17268 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) Dec 26 Waynesboro, PA 17268 Green Hill Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Grove-Bowersox Funeral Home, Ind 50 S Broad ST 17268 ames of Waynesboro PA powerson 23a. Parf. Enter the disease, or complications that caused the desertion, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiretory errest, Immediate Cause (Final 4 mosths disease or condition resulting in death) Colon Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? 20 No 1 ☐ Yes 2 ☐ No

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Baltimore, Maryland 21215-0020

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25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No

5 Pending investigation 2 Accident 6 Could not be 3 TI Suicide 26f. Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 T Homicide

1 De Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

schael House eddress of person who completed cause of death (Item 23a) (Type, Print)

11110 Medical Campus RD 21792 Michael J. McCormack, MD Hagerstown MD

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** December 21 Howard Charles KNOX Sr. 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deetl Examiner Washington Hagerstown Washington County Hospital 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min 1X M 2□ F Months Days Hours Yrs. 213-24-5751 73 Director March 16,1927 Maryland Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or frama 23a or 28a-f shot traumatic event, the Medical Examiner must be notified as 1 ☐ Yes 2 ☒ No Washington Directo Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21742 18644 Amanda Lane Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Baca - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: P white 3 ☐ Widowed 4 Ø Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Heelth and Mental Hygiene. Important: If Item 27 Is marked other than 'n any injury or other traumatic event, the Head bace. College (1-4or 5+) Elementary/Secondary (0-12) orchard fruit picker 0 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lula Pearl Sims Howard Freeman Knox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18644 Amanda Lane, Hagerstown, Md. 21742 Norman C. Knox - son 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12-23-00 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 21. Signature of Fungral-Befvice License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Finet disease or condition resulting in deeth) accident. torus Examiner Due to (or as a consequence of) Physician/Medical Examiner signed by the attending physician end be datached for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of): thet Initieted events resulting in death) Last Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uas contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown The lew requires thet by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed Is certificate has director, page 2 s 1 Yes 2 JA 1 Yes 2 LNO Division of Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□No 10 After this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 1 DiNetural Certification: 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred ours effer death.

Neval Director: After the filled in by the funer. 5 Pending Investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde within 24 hours e To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, end due to the causa(s) and manner es stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. edical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier Nuos 021457 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABOUL WAHER UP - 12921-OAK HILLAVE HAGERSTOWN. MD

DHMH 16 Rev 6/95

State

Registrar

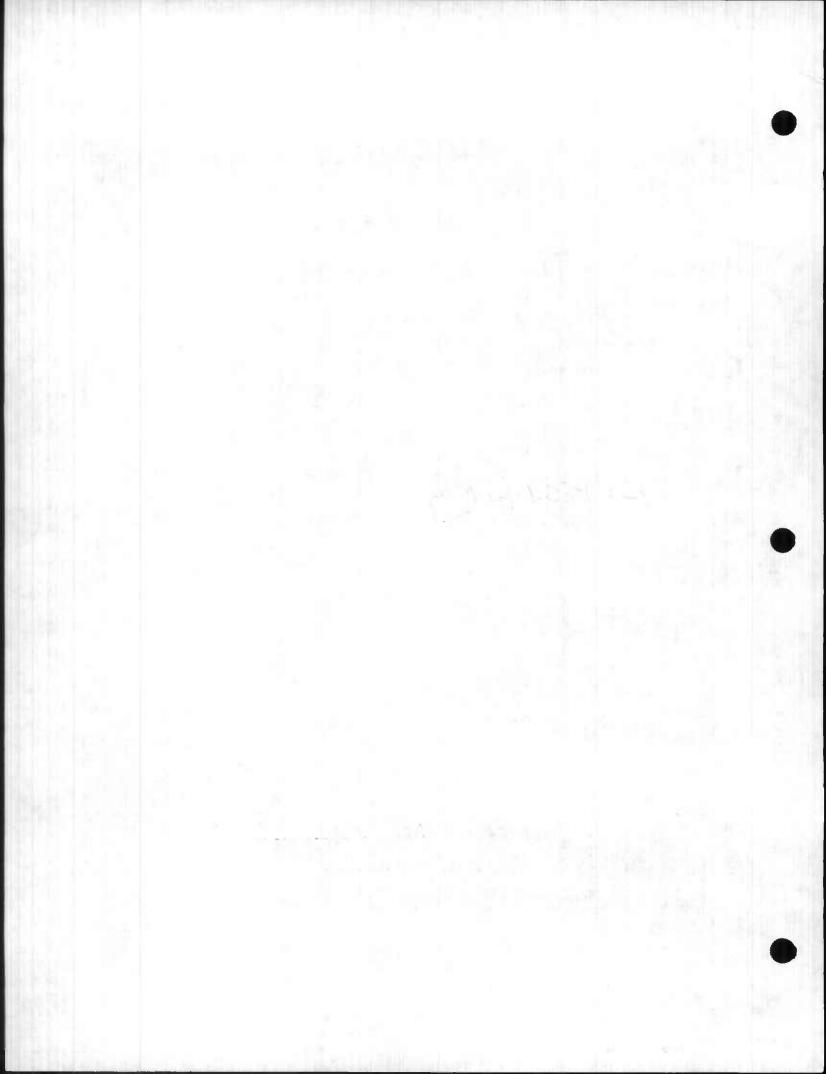
31. Date filed (Month, Day, Year)

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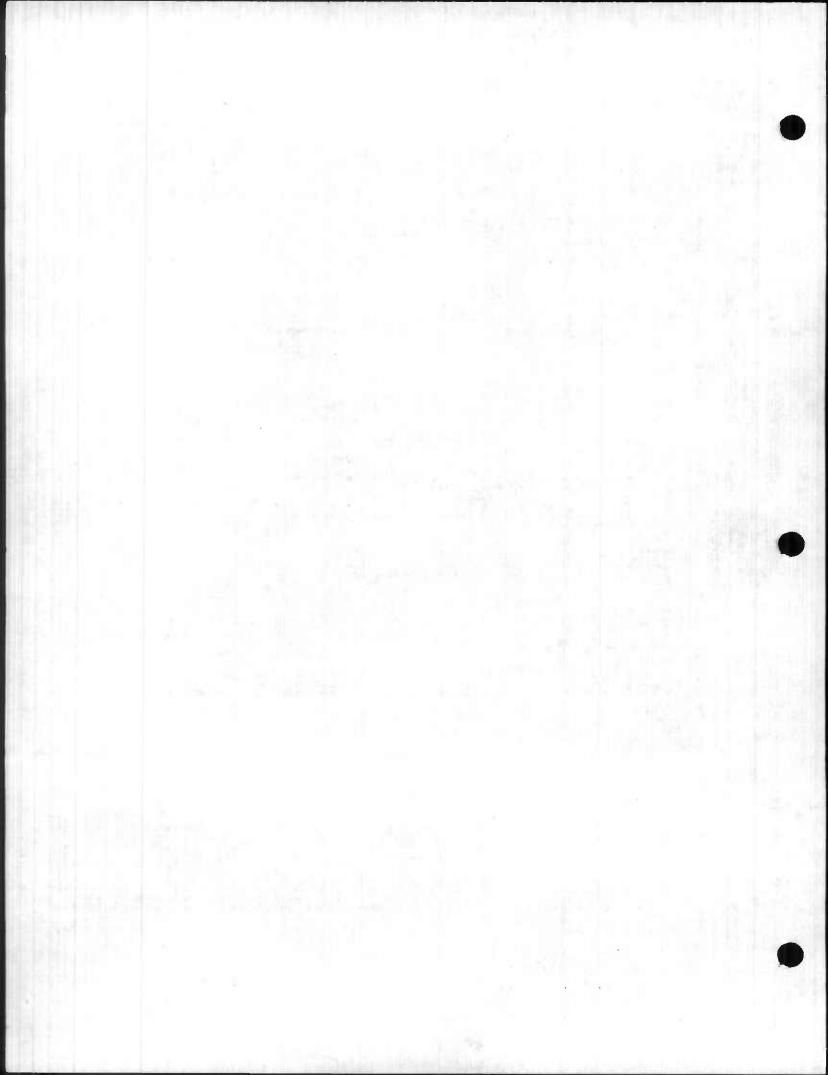
Howard Charles

32. Registrar's Signature

			State of Marylan	_	artment of F rtificate of			jiene	42	671	
	Dhusisian	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Yeer	3. Time of Dea	ath
	Physician /Medical	SHIRLEY	LAVON KL	NE			DECEMB	ER 5, 2	000	11:45	PM
Ä	Examiner	4a Facility Name (If not institution, give s					Location of Death	4c. County			
		FREDERICK MEMOR  5. Social Security Number 6. Sex		last hirthday)	If Under 1 Year	FREDEI		FREDE		nce (State or Fo	reinn
	Funeral Director		144 000 5	58 Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Dey 01-12-	1932	MARYI	ice (State or Fo y) .AND	Ji Gigi i
	P .	Usual Residence of Decedent									
	show of s	10a. State 10b. County		y, Town or Lo					10	d. Inside City L 1 ☐ Yes 2\(\bar{\chi}\)	
	the M	MARYLAND FREDERIC	CK FR	EDERIC	10f. Zip Code			10g. Citizen of \	What Countr		
	Mith Dir	5923 DORSEY DRIVE			21703			UNITED			
	urs effer deeth with the Mei al', or hems 23a or 28a-fa xaminer mist be notified by Funeral Director		12. Was Decedent Ever In U	S. 13.	Was Decedent of H	hispanic Origin? (	Specify Yes or No-	14. Rac	e - America	n Indien,	
0	or he	1 Never Married 2 Married	Armed Forces?  1  Yes 2 No If Yes, Give		f Yes, specify Cuba 1 ☐ Yes <b>¾</b> ☐ No	Specify:	nto racan, etc.)		ck, White, e		
90	filed within 72 hours efter deeth with the Meryland Hydrian. Hydrian "partural", or items 23s or 28s-f show ant, the Hed call Examinar must be notified at an Completed by Funeral Director.	3 ☐ Widowed 4 ☐ Divorced	Yaer or Dates:								
Maryland 21215-0020	in 72 and	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done DO NOT use ratire	during most of wo	orking	16b. Kind of B	usiness/indi	ustry	
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9		17. Father's Name (First, Middle, Last)				18. Mothar's Na	me (First, Middle,	Maiden Surnan	18)		
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Mai	0 0 0	19a. Informant's Name/Ralationship (Ty)					Pural Route Numbe				
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Itimore,	00- 7	1 Buriel 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		metory or other ple HTS CEME		2/09/2000	RRIINCI	TCV	MADVI AN	VID.
a	pemit. Peg Department Important: I any Injury o pnce.	21. Signature of Funeral Service License				ss of Fecility S	CAUFFER F	UNERAL	HOME.	P.A.	.VD
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Q		resulting in death) Last									
Box	at the death certific d by the attending poetached for use est Physician/Mec	d	• **								
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H	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by it Medical Certific		lician: To tha best of my kno ner: On the basis of examina and manner steted.								
	within To the comp	29b. Signature and title of certifier	s M		29c. Licens	se number		29d. Date signe	d (Month, E	Dey, Year)	
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		30. Name and address of person who co	4		Print)	FRE	DERICK /		- 17	we.	
		GERACE 1. SH 171 1 31. Date filed (Month, Dev, Year)	32. Registrar's Signa		AFFAIR	FI	GDERICK,	40	2170	2/	
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mena		1,27 per me G791 1/10/0 1. Decedent's Nama (First, Middla, Le			Cert	incate o	Death	2. Date of De	Reg. No. Day	Year	3. Tima of D	Death	
	Physician /Medical		KEILHOLTZ		KEME	RY	T	DECEM	BER 07	2000	1605		
	Examiner	4a Facility Nama (If not institution, given HOWARD COUNTY	ra street and number HOSPITAL	)			4b. City, Town, or COLUMBIA		h 4c. County HOWAI				
	Funeral		Sex 7. A	ge (in yrs. last		If Undar 1 Ya			ay, Year)	9. Birthple Count	ace (State or	Foreign	
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	inyland thow	10a. State 10b. County		10c. City, To	own or Loca	ation				10	d. Inside City		
	the Marylan r 28a-1 ahow horified at	MD. ANNE AR	UNDEL	GLE	N BUF	NIE 10f. Zip Code			10g. Citizen of	What Count		2   NO	
	fiter death with the Maryland r thems 23a or 28a-f show finer must be notified at Funeral Director	450 GLENMAR RD.	APT B2			2106		243	U. S.		ıyı		
	her death	11. Marital Status	12. Was Decedent Armed Forces	t Evar in U,S.	13. W	1	f Hispanic Origin? (Suban, Maxican, Puar	Specify Yes or No to Rican, etc.)	o- 14. Rac Bla	ca - America ck, White, e			
	s, Maryland 21215-0036 and 2 should be filed within 72 hours after eath and Mental Hygiene. The training to th	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Giva Year or Dates:	No		□Yes 2以 N				WHIT	E		
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	1 21215-0 ed within 72 ho ygiene. The trian maturit, to the distribution of the distri	Etementary/Secondary (0-12)	College (1-4or	5+)	life. D	ONOT use ret ISTERED	ired)		HEALT	LI.			
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	ylan	CLIFFORD k						INE SELL			0.41		
	Mai nd 2 st lith and 27 Is m	19a. Informant's Name/Relationship						t end Number or Rural Route Number, City or Town, State, Zip Code)  ARMY DR., FORT MEADE, MD. 20755					
	DIC TO THE TO THE THE THE THE THE THE THE THE THE THE	20a. Method of Disposition  1 Duriat 2 Cramation 3	20b. Place of Disposition (Name of Date 20c. Location - City										
	Baltimor. pemit. Pages Department of I freportent: If its any injury or of once.	4 Donation 5 Other (Speci	(y)		RDENS 12/11 FREDERICK, MD.								
	Ball permit Oppar frmpor any Ir	21. Signature of Funeral Service Lice	hile	را				SKILES FUNERAL HOME ., POB 427, EMMITSBURG, MD. 2					
•	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)		PNEUMOTH  Due to (or as	a consequ		DISEASE				Onset end D	eath	
	ate be assecuted hystelan and the burial-transit	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying		Due to (or as	a consequ	ence of):							
	P.O. Box 68760, nat the death certificate be assecuted by the ettending physician and letteched for use as the burial-transit Physician/Medical Examin	Cause (Disease or injury that initiated events resulting in death) Last	d	Due to (or as	a consequ	ence of):				t 1 t			
	o death	Part II. Other significant conditions	contributing to death	but not resultin	g in the und	derlying cause	given In Part I.	23b. Dld	tobacco use co	ontribute to	the cause o	f death?	
	igned by the ab by Physic	HYPERTENSIVE ARTERIOS	SCLEROTIC CA	RDIOVASC	ULAR D	ISEASE;	ALEXES	10	Yea 2 No	3 Prob	ably 4 U	Jnknown	
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	Of Vita Physician: ribis certific rial director,	25. Was casa referred to medical examiner? 1 💆 Yes 2 □ No	Hospitet:	iont 0 7 5 7	Outrations	2 DOA	Other-	ath (Check only		has /Spacih	4		
	9 Physic er this consert direction. To	27. Manner of Death	28a. Date of Inj (Month, D		b. Time of Injury	3□ DOA   28c. In	njury at Vork?	Home 5 Res 28d. Describe	how injury occu		"		
	Division of Vital Records, to the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be a Medical Certification: To Be Completed by	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident 3 Suicide 4 Homicide 4 Homicide (Month, Day Year) Injury Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							(Street end Num own, Stete)	ber or Rura	l Route Numb	ber,	
	To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier 1 Certifying Pl	hysician: To the best miner: On the basis of and manner s	of axamination	dge, deeth and/or inve	occurred et the estigation, in m	time, date and plac y opinton, death occ	e, and due to the urred at the time	cause(s) and m , date and place	enner es st , and due to	ated. the cause(s)	)	
•	Toth within To the comp	29b. Signature and title of certifier	Eaus)				ense number C.M.E		29d. Date sign DECEMBE		Dey, Year) , 2000		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Street, Baltimore,							more, Ma	rylan	d 2120	)1	
	State	31. Date filed (Month, Day, Year)	32. Regist	trar's Signature			a Val						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death Month 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death 2000 Dec. 27 7:35 am Helen Frances Lipscomb 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, give street and number) 4c. County of Death Garrett Co. Mem. Hospital
Social Sacurity Number 6. Sax 7. Oakland If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Months Days Hours 1 M 20 F Yrs 216-30-1691 Md. 83 Oct 29 1917 Usual Rasidanca of Decedent 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County Md Kitzmiller Garrett 1 ☐ Yas 2 No 10g. Citizen of What Country? 10f. Zlp Coda 10e Street and Number 5509 Kitzmiller Rd. 21538 USA 14. Raca - Amarican Indian, Bleck, White, atc. 12. Was Decedant Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 1 Yas 2X No If Yas, Giva Yaar or Datas: 1 Nevar Marriad 2 Married 1 Yas 2X No Specify: Specify. 3 Widowed 4 Divorced White 16a. Decedant's Usuel Occupetion (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decadant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housewife 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumame) Newton McRobie Carrie Puffenbarger 19b. Malling Addrass (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) James Lipscomb 5509 Kitzmiller Rd Kitzmiller, Md 20b. Place of Disposition (Name of camatary, cramatory or other place) 20c Location - City or Town, Stata 20a. Mathod of Disposition Data 1√ Burial 2 □ Cramation 3 □ Ramovel from Stata 4 □ Donation 5 □ Othar (Specify) Kalbaugh Cemetery Dec 29 2000 Elk Garden WV 21, Signature of Funeral Service Licansee 22. Nema and Addrass of Facility David A. Burdock FH 21538 Approximata 0240 710 Church St. Kitzmiller, Md tar tha moda of dying, such as cardiac or raspiratory arrest, of Lenter the disaasa, or complications that causad the death. Do not antar Intervel Batween Onset end Death Immediata Causa (Final metastatic colon cancer diseasa or conditio rasulting in daath) 3 years Due to (or as e consequanca of): Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated evants resulting in daath) Last Dua to (or as e consequence of): Due to (or es a consequence of): Part II. Other aignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No coronary artery disease with angina & congestive heart failure; diabetes mellitus type 2; hypothyroidism; 24b. Wara autopsy findings availabla prior to complation of causa of deeth? 24a. Was an autopsy hypertension; gout 2 No 1 □ Yas 2 □ No 1 Yas 25. Was case rafarred to medical axaminar? 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1□ Yas 25 No Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. injury at Work? 28d. Dascribe how Injury occurred 28h. Tima of 5 Panding invastigation 1 Naturel 2 Accident 1 Yes 2 No 6 ☐ Could not be 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28e. Plece of Injury - At home, farm, street, factory, offica building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the fime, date and place, and due to the causa(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifian

that the death certificate be executed physician and s the burial-transit Box 68760. 38 attending for use as P.O. ed by the a Division of Vital Records. Sign The law requires is certificate hes director, page 2 or Attending Physician: after deeth. Director: After this certifica funeral ector: N Funeral Directions after No. 124 hours after Hospital To the Vithin 2 To the Complet

**Physician** 

/Medical

Examiner

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Funeral

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**Funeral** 

Director

Hygiene. other than "netural", or frame 23a or 28a-f show ent, the Medical Examiner must be notified at

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**Physician** /Medical

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10

Certification:

Medical

(Check only one)

altimore, Maryland 21215-0020

Registrar

Margaret Kaiser, M.D.; 31. Data filed (Month, Day, Year) DEC 2 7 2000

29b. Signatura and titla of cartifian

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 13079 Garrett Highway; Oakland, MD 21550 32. Registrar's Signatura



Eller

29c. Licanse number

D26650

29d. Data signed (Month, Day, Year)

12/27/2000

**DHMH 16 Rev 6/95** 

WE TOWN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 42674

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Examine	_	4a Facility Name (i	If not institution, given	ve street and nu	ım <i>ber)</i>		11/1		- 1	4b. City, To	wn, or Lo	ocation of Death	4c. County	of Death	
500	п	Dennet	Road I	Manor	Nur	sina	Home	2		0ak1	and		Garr	ett	
Funeral		5. Sociel Security N	lumber 6.	Sex		e (In yrs. last b		If Under 1	Year	If Under Hours		8. Dete of Bird (Month, Da			ace (State or Foreign
Director		214-42-00	092	1□M 2⊠F		95	Yrs.	WOULTS	Jays	110013	IVIICI,	JUNE 7	, 1905	MARY	YLAND
P		Usual Residence of													
styles the		10a. Stete	10b. County			10c. City, To								10	ld. fnside City Limits 1 Ñ Yes 2 □ No
M Par	5	MD	GARRETT			MT	. LAK	KE PAR	K						TLATES 2LINO
F 22 F	2	10e. Street and Nu						10f. Zip C	ode				10g. Citizen of V	Vhat Count	ry?
21215-0020  s with 72 hours efter death with the Menyland iene. Then "naturel", or Name 23e or 28e-f show the Medical Everyland must be notified at	Funeral Director	"N' ST	TREET					2155	0				USA		
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offe offe			ied 2 Merried	1 Yes	2X) N	No.		☐ Yes 2		Specify:			Specify		
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21215-0020 d within 72 hours of giene. or than "naturel", or i me wed et l'essen	Completed	(Spec	15. Decedent's E	ducation ade completed)		16	a. Decede	ent's Usual 6 ind of work O NOT use	done	ation during mos	t of work	ing	16b. Kind of Bu	usiness/Ind	ustry
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N DOL		/	(First Adiddle Con	4)			HOME	EMAKER		40 Mah	-de Alessa	- /Final Blistella			
DD fittel H double over	m	17. Father's Name EMANUEL	(FITST, MIGGIO, LESI	,		IZTNIC							Maiden Sumen		
should not marke	2					KING					EMIL				
		19a. Informant's N			מפושו								er, City or Town,	State, Zip	Code)
CENE	-	SHARON DO		MDDAUGE	ILEK			ition (Nerne		04	UAK.	LAND, M		O'4 T	- 0
SOFE		20e. Method of Dis	position Cremation 3	Removal from	State	cemet	tery, cremi	atory or other	er ple			Date 100	20c. Location -		
altim nit. Per artmen ortant: injury			5 ☐ Other (Speci			PLEAS	SANT	VALLE	Y C	EMETE	RY 1	2/29/00	OAKLAI	ND, MA	ARYLAND
Baltimore, permit. Pages 1 at Department of Hee important: If them: eny injury or othe		21. Signature di Fu	meral Service Lice	nsee			22.	Neme and	Addre	ss of Facili	ty	P.O.	BOX 243	3	
W 80558		Stoling	24xle	ust	M	00167	DI	JRST F	UNI	ERAL 1	HOME	- OAKL	AND, MD	21550	)
		23a. Part1. Enter t	he disease, or con	plications that	caused	the death. Do	o not ente	r the mode	of dylr	ng, such es	cerdiec	or respiratory a	rrest,		Approximete Interval Between
Physician														1	Onset and Deeth
/Medical		Immediete Cause disease or condition	(Finel	Con	aes	stive	Hear	rt. Fa	i 1	ure				7	years
Examiner		resulting In deeth)		a		Due to (or as					gent)				1 3 3 3 3
p =	Examiner			, Ath	ero	oscler	otio	car	di	ovas	CB1	ar dis	ease	8	years
Box 68760, sath certificate be executed ettending physicien and for use es the bunel-transit	Eam	Sequentially list co	enditions,	0,		Due to (or as									1
ien sien		Sequentially list co if any, leeding to in cause. Enter Under Cause (Disease or	nmediate erlying											1	
68760, flicete be exp physicien es the burie	S	that initiated events resulting in death)	5	C		Due to (or as a	a consequ	ence of):					4-5-5	1	- 1-100-1-1
X 6	Medicai		A	-											
BO)				d											
O. Bo e death the etten hed for u	Physician	Part II. Other signif	licant conditions	contributing to d	leath bu	ut not resulting	in the un	derlying cau	se giv	en in Part I	1.	23b. Dld	tobacco use co	ntributa to	the cause of death?
P.O. that the de detached	5	conilo	onset	domont	1 .	dia	hot	0 C m C	1 1	itua		10	Yes 2 No	3 Prob	ably 4 Unknown
C X D	by	senite	onset	dement	la	, ula	bec	es me	: T T	itus					
Records, P						tvr	e t	WO				24a. Was	an autopsy	ava	re eutopsy findings ilable prior to
lew re law re 2 sh	De					011	, , ,		-		_				npletion of cause leath?
The lever at the has pege 2	Completed											10	Yes XINO	1	Yes 2□ No
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Of Vita Physician: this certific	0	examiner?	No	Hospital:	Inpatie	nt 2 ER/O	Outpatient	3□ DOA	Oth	205			dence 6 Oth	er (Specify	·)
Physer this serel di	ä	27. Menner of Deat		28a. Date	of Inju	y 28b	. Time of	280	. Inju				how injury occur		
Division  or Attending I after death. Director: After d in by the funer	을 음	1 Natural 2 Accident	5 Pending investigation		niri, Daj	y rear)	Injury	М		Yes 2	No				
Divisio	2	3 ☐ Suicide 4 ☐ Homicide	6 Could not to	288. Place	e of Inju	ury - At home,	farm, stre	et, factory,	office				Street end Numl	per or Rura	Route Number,
D page	Certification:	4   Homicide		Dulid	ling, etc	c. (Specify)						City or To	wii, Sielej		
Hospital 24 hours (24 hours (24 hours) (31 h		29a. Certifier	1 ☑ Certifying Pl												
DIVISION To the Hospital or Attent within 24 hours after deal To the Funeral Director: completely filled in by the	edicai	(Check only one)	2 Medical Exa	miner: On the b	asis of	examinetion a sted.	and/or inve	estigation, in	n my c	opinion, dea	th occur	red et the time,	date and place,	and due to	the cause(s)
within 2 To the comple	100	29b. Signeture and	title of certifier				111	29c. I	Licens	se number			29d. Date signe	d (Month, I	Dey, Year)
			1	MA	21	Maria	ne	DO	002	25759		I	ecembe	r 26	, 2000
	-	30. Name and addr	ess of person who	completed cau	se of de	eeth (Item 23s	) (Typa P								
1		Walter		1000					1	06 0	omo	tory T	d Age	215	
State	-	31. Date filed (Mon	th, Day, Year)	32. F	Registr	ar's Signature	DUX	2711	B	.00 0	eme	CETA L	U ACC	Tuen	C FID
Registra	_		DEC 2	2000	1	America	13	. 16	533	de					
					1										

DHMH 16 Rev 6/95

Registrar

DEC 27 2000 12000 B. Frank

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician
/Medical
Examiner

**Funeral** 

Director

with the Maryland

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylan Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any righty or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0020

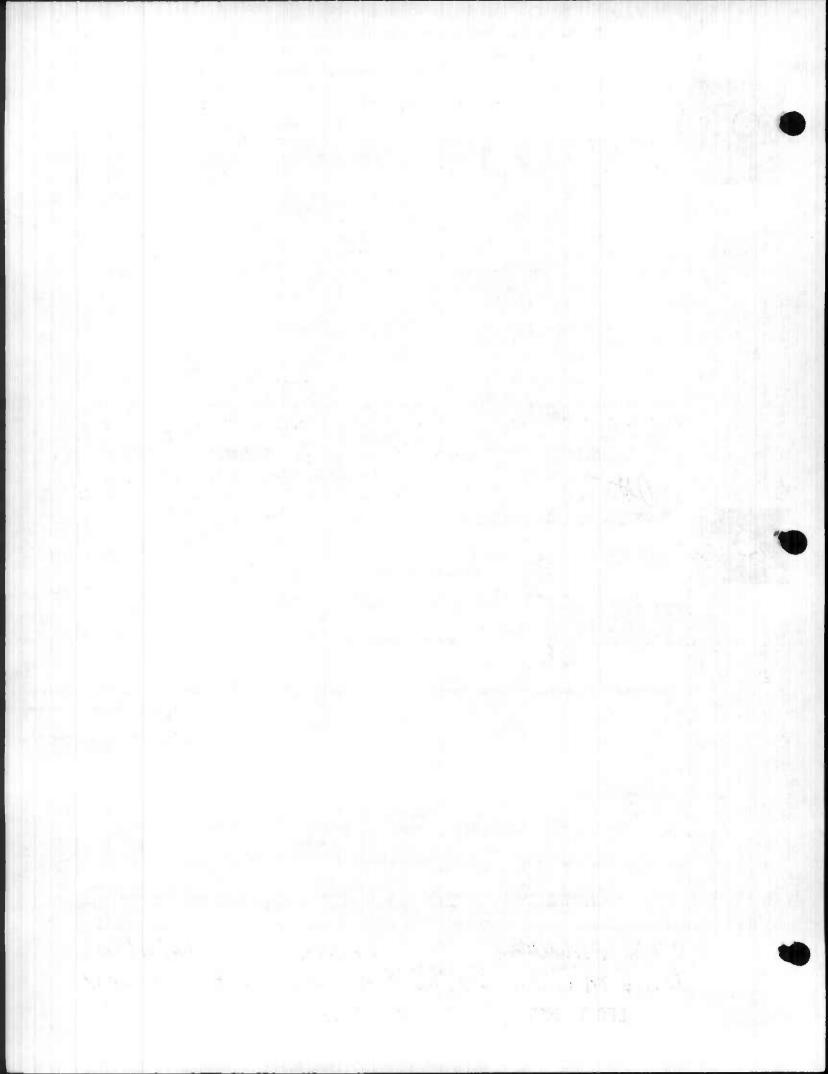
Physician /Medicai Examiner Division of Vital Records, P.O. Box 68760,

To the Hoopital or Attending Physician: The law requires that the death certificate be executed within 24 hours eiter death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

	Decedent's Neme (First, Midd		7 7 7777	DMA TO	NIC			2. Dete of Do		2000 eer		of Deeth
	4a. Fecility Neme (If not institution	LOTTIE		RTA LO	NG	- (46	City Town	r Locetion of Deer				0 P
ı									4C.	County of Dec		
١	WESTMINSTER  5. Social Sacurity Number	T		last birthday)	If Under 1	1	ESTMIN If Under 24 Hr		irth	CARRO	rthplece (Stet	or For
1	213-36-8634	1□M 2∏F	9		Months	Days	Hours Mi	8. Dete of Bi (Month, Di 7 / 1 4 /		0	RYLAN	
ŀ	Usuel Residence of Decedent  10e. Stete 10b, County	,	10c Ci	ty, Town or Loca	ation						I and the same	00. 11
ı	MD. CARE			ESTMIN							10d. Inside	os 2 🕅
ŀ	10e. Street end Number		AA	POINTN								2 2 (2)
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-	45 WASHINGTO	12. Was Decede		11		157	pople Origin?	Cassifu Van ar N	US		erican Indien.	
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	3√ Widowed 4 □ Divorcad	If Yes Give		1[	☐Yes 2	₹ No	Specify:			Specify: WI	HITE	
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ŀ	17. Fether's Neme (First, Middle,	1 = ===			OWI	1ER					STORE	
			BLIZZ	ZARD				eme (First, Middle A ELLEN				
-	19a. Informent'e Name/Reletions		THER	19b. Meiling	Address (	Straat a		Rurel Route Numb			Zip Code)	
	MAURICE E. B	LIZZARD		334 \$	STONI	ER A	AVE.,	WESTMIN	STE	R, MD	. 2115	57
	20e. Method of Disposition	0.00	20b. F	Plece of Disposit	tion (Neme	of		Dete	20c. Loc	cation - City or	Town, Stete	
	1 反 Burial 2 ☐ Cremation 4 ☐ Donetlon 5 ☐ Other (S	pecify)	CARE	ROLLTON	CHU	JRCF	H OF	12/22/0			,	ID.
	21. Signature of Euneuri Service	Licansee		22. 1	vame and	Address	of Fecility F	LETCHER	R FUI	NERAL	HOME	
l	DI HAD			254	1 E.	MA	IN ST.	, WESTN	INS	TER, N	MD. 21	157
Ì	23a. Per T. Erner the dineese, or shock, or man injure. List	complications thet cause	sed the deat	h. Do not enter	the mode	of dying,	such es cardia	ac or respiretory e	errest,		Approxim	ete
l	orioon, or realizable. Else	only one code on each	A.								Onset en	
l	Immediate Cause (Finel disease or condition	(1)	A								100	an
l	resulting in death)	0.	Due to (c	or es a conseque	ence of):						1000	P
ı		- ASC	CVD								200	n
ŀ	Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying	0.	Due to (c	or es a consequa	ince of):							1
	causa. Enter Underlying Cause (Diseesa or Injury	6									1	
	thet initieted events resulting in deeth) Last		Due to (o	r es e conseque	nca of):							
l		d										
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	Pert II. Other significant condition	ons contributing to death	h but not res	ulting In the und	erlying cau	se giver	In Pert I.	23b. Dld	tobacco	use contribut	a to the cause	of deat
								10	Yes 20	No 3□ F	Probably 4	Unkno
								24e. Wes	en eutops	sv 24b.	Were autops	/ finding
								perfo	ormed?		completion of	rto
											of death?	
								10	Yes 2	(No	1 ☐ Yes 2	□ No
	25. Was casa referred to medical						00 54 - 10					
	25. Wes casa referred to medical examiner? 1 □ Yes 2 ☑ No	Hospitel:	etient 2	EB/Outpatient	3 DOA	Other		eth (Check only		DO# (6		
	examiner? 1 Yes 2 No  27. Menner of Deeth	Hospitel: 1 ☐ Inpe		ER/Outpatient 28b. Time of	3□ DOA	Other	4 Nursing	Home 5 Resi	dence 6		ecify)	
	examiner? 1 Yes 2 No	Hospitel: 1 Inpe				Other Injury e Work?	4 Nursing	Home 5 ☐ Resi	dence 6		ecify)	
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Registrar



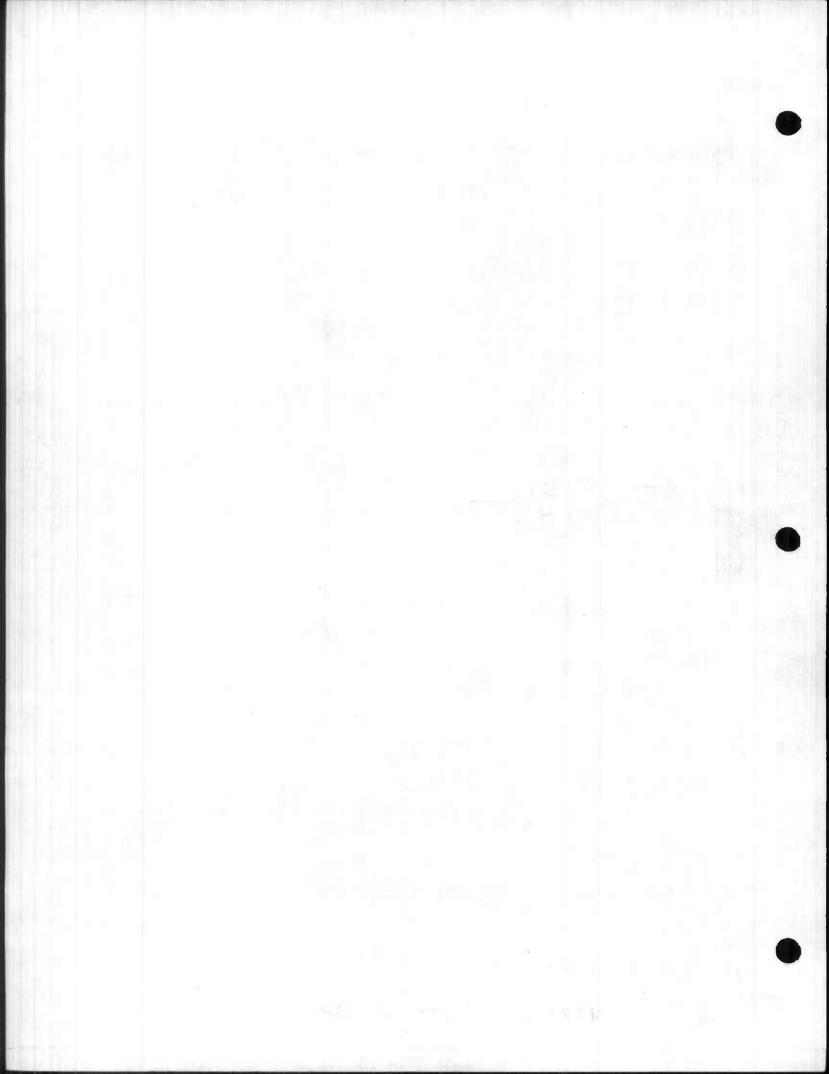
# Please Type or Print in Biack indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 4 2676 Certificate of Death

							Cer	uncai	e UI	Dealli		Re	eg. No.			
		_	1. Decedent's Name (First, Midd	le, Last)								2. Date of Deat Month	h Day	Year	3. Time of Death	
	Physicia	_	Stephen Theop	hilus LON	1G								2000		1100 AN	1
	/Medica	_	4a Facility Name (If not Institution							4b. City, Tov	vn, or Lo	cation of Death	4c. County		11	
4	Examine	T.	13549 Paradis							Пос	orat	OTT	Line	hina		
-	· · · · · ·		5. Social Security Number	6. Sex	7 Ac	e (In yrs. last birl	th day)	If Under	1 Year		erst			hing		-
1	Funeral		163-14-5550	1 ☑ M 2 ☐ F			Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day,	Year)	Coun	lace (State or Foreign	
	Director	-	Usual Residence of Decedent			70						Dec.24,	1921	Penn	sylvania	
	pur *	-	10a. State 10b. County			10c. City, Town	or Loc	cation						1	0d. Inside City Limits	
	aho	-	The season of th												1 ☐ Yes 27 No	
	N of Page	န္တ -		shington		пая	gers	town							1020	
	or 2	Director	10e. Street and Number					10f. Zip				1	0g. Citizen of		try?	
	ter death with the Merylan terms 23a or 28a-f ahow		13549 Paradise	Drive					2174				USA	λ		
	ep E 5	Funeral	11. Marital Status	12. Was De	ecedent Forces?	Ever in U,S.	13. V	Vas Dece	dent of l	Hispanic Original Mexicen	in? (Sp	ecity Yes or No- Ricen, etc.)		ce - Americ ck, White,		
0	or h		1 ☐ Never Married 2 ☑ Mar		s 2 🗆					Specify:						
9	Nurs Paris	2	3 ☐ Widowed 4 ☐ Divorced	Year or	Dates:	1944-46		162	2124110	Specify.			Specif	y: Wi	nite	
21215-0020	72 hours after death with the Meryland natural', or flerns 23s or 28s-f show	Completed	15. Deceder	t's Educetion	-41	16a.	Deced	ient's Usua	al Occup	petion during most	of work	ina	16b. Kind of B	usiness/in	dustry	
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21	filed within Hygiene. ther then ont, the M	E	9	0	(1 401	,	mac	hini	st				truck	manui	acturer	
	建工与を	De C	17. Father's Name (First, Middle,	Last)				elfa-	3	18. Mothe	r's Name	e (First, Middle, A	Maiden Sumar	ne)		
lan	Mental Mental wrked	9	George Long, S	r.						Mar	v Fi	alka				
7		0	19a. Informant's Name/Relation			19h	Mailin	n Address	(Street			al Route Number	City or Town	State Zir	Code)	
Maryland	0 0 2 9								,							
e,	1 end Health Im 27 ther tr	-	Dorothy D. Lon	g - wile							ive,		20c. Location		and 21742	_
0	Se of		1 ☑ Burial 2 ☐ Cremation	3 Removal fro	m State	20b. Place of cemeter	*									
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Baltlmore,	Departm Departm Importa any Inju		21. Signature of Feneral Service	Licensee			22.	. Name ar	nd Addre	ess of Facility	y M	INNICH F	UNERAL	HOME		
	Dep de de de de de de de de de de de de de		Sall	7/100/1	m	uch	1	415 E	. W:	ilson	B1vc	l., Hage	rstown	, Md.	21740	
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107	Physician		shock, or heart failure. Lis						. 1					1 9	Onset and Death	
	nviearear	1	Immediate Cause (Final	CA	CO	POINTE	3	MA	h	PMI	anl	WGE.		1	LEATI	
	Examiner	-	disease or condition resulting in death)	a. 41)	2110					VIIIII	dol	3yc		1	yenia	
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	ted nsit	Examiner		b. 630	7114	MARKA		MAIC	10	853				- 1	4600	
	and	×	Sequentially list conditions, if any, leading to immediate	1	1/2	Due to (or as a	consequ	uence of):		Acc				1	FADA	
9	be a ician buria		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	6.1	LIA	EN WE	15	111	1t	NSE				10	ESTO	
68760	certificate be assocuted ding physician and isa as the burial-transit	edical	that initiated events resulting in death) Last	On.	۸. ۸.	Due to (or as a c	onsequ	uence of):								
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8	certificate rector, pag		25. Was case referred to medical	N I						OC Place	of Door					_
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			P - 1/1/V	10501-81	m	19			D	9	14=	5	101	90	00	
		-	30. Name and address of person	who completed ca	use of	death (Item 236)	Type, I	Print)	-	2001	/	00 0	71	ירטו		
			11110 MOD	(B) (1	M)	Mas K	1)	111	90	C1101	MN	m)	611	16	7	
	State	е	31. Date filed (Month, Day, Year	9000 32	Poist	rar's Signature	4	1	1	11						

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State of Maryland / Department of Health and Mental Hygiene ADMEND ITEM: 26 PER VERBAL RESPONSE G793 3-16 pathicale of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Year December 21, 2000 **Physician** JOSEPH ALLISON LEAPLEY 1:53 am /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5486 Hallowing Point Road Calvert Prince Frederick | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 03/04/19 6. Sex 1.XXM 2□ F 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Yrs. 1929 Director 579-30-1001 Wash., D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at Yes 2 No Director Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 2900 Conn. Ave, NW, Apt. 249 20008 Funeral U.S.A. Herra 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give 14. Race - American Indien, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: Specify: py 3 Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Property Manager Real Estate permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oth any Injury or other traumatic event once. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Jacob Allison Leapley Helen McProuty 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Laura L. Darch / daughter 5486 Hallowing Point Road, Prince Frederick, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/23/00 Annapolis, MD Hillcrest Memorial Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or compleshock, or heart failure. List only or Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) Examiner 9 anc ician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Records, 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 1 Yes 2 No Division of Vital Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) DAUGHTER RESIDENCE P 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. tnjury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Attending death. 1 Yes 2 No To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide \*\*Descritiving Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner es steted.

\*\*Descritiving Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 052097 30. Name and add pleted cause of death (Item 23a) (Type, Print) Stockley Rd. Prince trederik mI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 2 2 2000 D Geneva Registrar

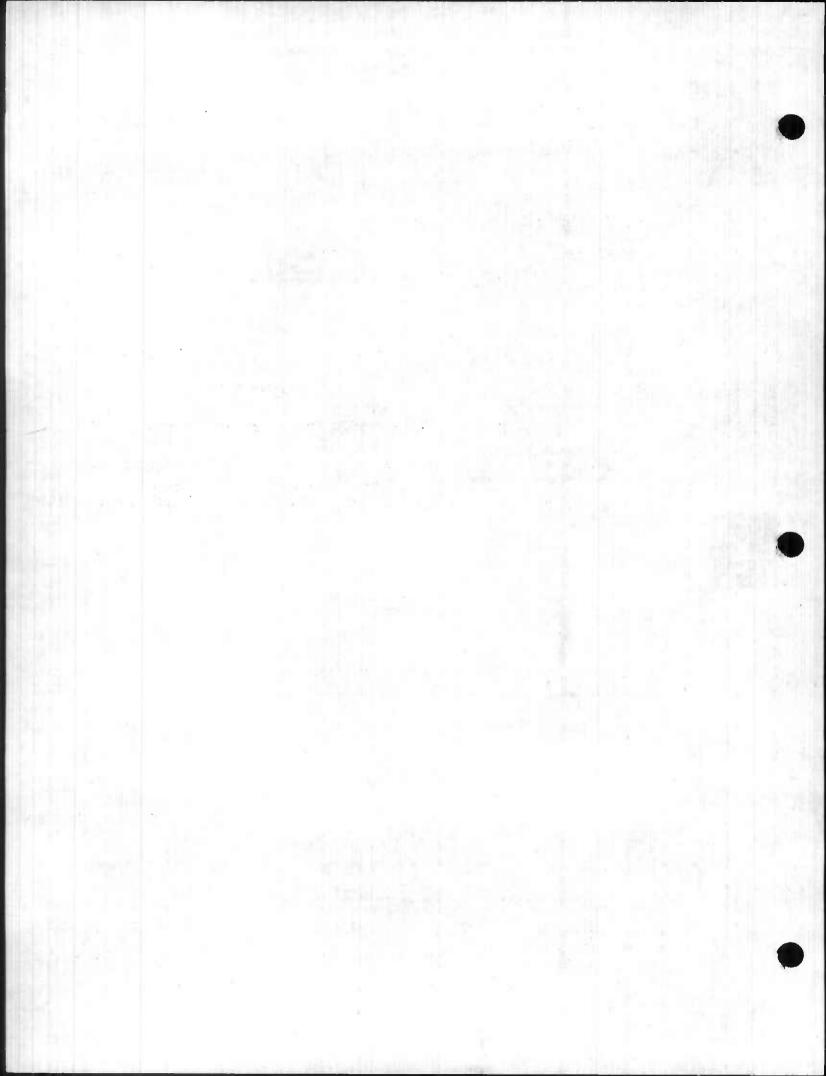


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/Medica	An English Name /// mat landflution who				4b. City, Town	Decemi or Location of Deet	- 1	2000 of Death	17:43
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Funeral Director	5. Social Security Number 6. St 227 13 0081	M 2DE	n yrs. last birthd	Months Da		Hrs. 8. Date of Bir (Month, Date of Bir Aug 25	th ly, Year) 5, 1961		ce (State or Foreign y) Sylvania
pu »	Usual Residence of Decedent 10a, State 10b, County	10	Oc. City, Town or	Location				100	d. Inside City Limits
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036 urs after deeth with the Marylar al', or Itema 23a or 28a-f ahow Est other must be notified at	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	er in U,S. 1	3. Was Decedent of If Yes, specify C		? (Specify Yes or No uerto Rican, etc.)	Specify	e - Americar ck, White, et	c.
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Maryland d 2 should be file th and Mental hy 7 is marked oth treumatic avent	19a. Informant's Name/Relationship (7					r Rural Route Numb			
	Joseph W. Misko, 1			sposition (Name or crematory or other	Street	Frederick	20c. Location		
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프 교원원들	21. Signature of Funeral Service Licen					s Family			
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Physician	23e. Per1. Enter the diseese, or comp shock, or heart failure. List only of	plications that caused the one cause on each line.	e druith. Do not	enter the mode of	dying, such es ca	rdiac or respiretory e	errest,	1	Approximate nterval Between Onset and Death
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oartifica nding ph	Part II. Other significant conditions or	d							
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P.O. That the de detached detached	Part II. Other significant conditions co	ontributing to death but n	not resulting in th	e underlying ceuse	given in Part I.		Yes 22 No		the cause of death?
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on adding the stune of tune	1 □ Naturat 5 □ Pending investigation	12 Month Day Y	ear) Inju	40 M	njuryat Work? 1 □ Yes 2 □ 3 Wo	struck by	multiple	motor	vehicles
Division of or Atlanding Physical Action of the Atlanding Physical Atlantic Atlantic of the At	27. Manner of Death  1 Naturat 2 Accident investigation 3 Suicide 4 Homicide determined	28e. Place of Injury building, etc. (S TOAC			ice	28f. Location City or To Temple H	(Street and Number, State) 495 Iills, Mar	N. Tem	Route Number. ple Hills
25.25	29a. Certifier 1 Certifying Phy	ysicien: To the best of m niner: On the basis of ex and manner stated	amination and/o			place, and due to the	cause(s) and m	anner as sta	ited.
of the state of th	29b. Signeture and title a certifier	1 /		29c. Lic	ense number		29d. Date signe	d (Month, D	ay, Year)
ON CA	- X/	10	MA.	0	CME		Decembe	er 29.	2000
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DHMH 16 Rev 6/95

**ORIGINAL** 



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 2679

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Audrey Edna Murphy 28 2000 2:15 AM /Medical 4a. Facility Nama (If not institution, giva straet and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Egle Nursing Home Lonaconing Allegany | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Nonths | Deys | Hours | Min. | May 2 19 16 5 Social Security Number 215-68-7266 9. Birthplace (Stata or Foreign Country)
Ohio 7. Aga (In yrs. last birthday) **Funeral** 1 M XXE 84 Yrs. Director Usual Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, its Mexical Examiner must be notified at MD Garrett Swanton 1 ☐ Yas 2 ☐ No Director tha 10f. Zip Code 2 1 5 6 1 10g. Citizan of What Country? Rt 1 Box 205B Funeral 12. Was Dacedant Evar in U,S. Armad Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Wes Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 11 Marital Status 14. Race - Amaricen Indian, Black, White, atc. 72 hours aftar 1 □ Navar Marriad 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decadant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry permit. Pagas 1 and 2 should be filed within i Department of Health and Mental Hygiane. Important: if Item 27 is marked other than "n any injury or other traumatic event. Elemantery/Secondary (0-12) College (1-4or 5+) Unkown Homemaker Home 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Charles Morgan Susan Timney 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Diane Davis/Dau 18140 Md. Highway, Swanton, Md 21561 20b. Place of Disposition (Name of cametery, crametory or other place)
St. Peter's Cem 20a. Mathod of Disposition 20c. Location - Cltv or Town, Stata 1X Burial 2 Crametion 3 Ramovel from Stata St. 12/31/00 Westernport, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensae 22. Nama and Addrass of Facility Boal Funeral Home, 111 Church St. ame 10 21562 Westernport, Md. 23a. Part1. Entar the diseesa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiretory errast, shock, or heart failure. List only one cause on each line. Approximeta Interval Batween Onsat and Death **Physician** /Medical Immediate Causa (Final disaasa or condition rasulting in daath) Gear Examiner monic myocardial physician and the bunal-transit Saquantially list conditions, if any, laading to immediata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated avants resulting in daath) Last Dua to (or as a consequence of): Box 68760 Coneculized ather Due to for es e consequence of) 5 years Physician/Medical 88 for usa as P.O. ed by tha a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by t 1 ☐ Yes 2X No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed paga 2 cartificata 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was casa referred to medical axaminar? Be 26. Placa of Daath (Check only ona) ×16 Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 Yas 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Aftar this 28a. Data of Injury (Month, Day Year) 27. Mannar of Daath 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Panding death. 1 ☐ Yas 2 ☐ No 2 Accidant investigation Director: A 6 Could not ba 3 Suicida 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, straat, factory, office building, etc. (Spacify) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Di complataly filled in Cartifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) end menner es steted.

Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, date and place, and dua to the cause(s) end mannar stated. 29a. Cartifian (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signad (Month, Day, Year) 007004 2000

State Registrar

DHMH 16 Rav 6/95

L.R. MILES, JR., M.D.

30. Name end eddress of person who completed causa of death (Item 23a) (Type, Print)

57 JACKSON ST.

32. Ragistar's Signatura

LONACONING MD

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death Month Year **Physician** Margaret Moran McCormick December 8:25A 27, 2000 /Medicai 4e. Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Eale Nursing Home Lonaconing Allegany | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 16,1912 5. Sociel Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** 1 M 2 XF Months 88 213-22-3774 Yrs. Director Maryland Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. insida City Limits 28a-f show event, the Medical Examiner must be notified at MD. Allegany XXYas 2 No Director Lonaconing 10e. Streat end Numbar 10f. Zip Coda 10g. Citizen of Whet Country? 6 death with 4 Alleghany St. 21539 United States items 23a Funeral 12. Wes Decadant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status filed within 72 hours efter I ☐ Yes 2 X No 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 netural, or 1 ☐ Yas 2 ☒ No Specify: If Yas, Giva Yaar or Dates: Specify: White by 3 X Vidowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry i Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed wit Depertment of Health and Mental Hygiene Important: if item 27 is marked other tha any Injury or other traumatic event, Ins.) Once. Homemaker Home unknown 17. Fethar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meldan Sumeme) Be Ellsworth E. Crowe Margaret Teasdale 10 19a. informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Barbara Moses/ daughter 6 Alleghany St., Lonaconing, Maryland 21539 20e. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 12/29/ 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from State Laurel Hill Cemetery 4 ☐ Donation 5 ☐ Othar (Spacify) Barton, Maryland 2000 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Boal Funeral Home 12 111 Church St., Westernport, Maryland 21562 23a. Part I. Enter the disease or complications that caused the deeth. Do not antar the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwe Onset end Daath **Physician** /Medical Immediata Ceuse (Final hour disaasa or condition rasulting in daath) Examiner Physician/Medical Examiner that the death certificate be executed -trensit Sequantially list conditions, if any, leeding to immadiata causa. Enter Undarlying Causa (Disaasa or injury thet initieted avants rasulting in daath) Last pue ettending physician efor use es the buriel P.O. Box 68760. Generalized Ce Dua to (or as a consequenca of) Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed be de binen Records, þ 24b. Wara autopsy findings available prior to complation of cause of daeth? Completed 24a. Was en autopsy performed? page 2 s certificete 2 No 1 ☐ Yas 2 ☐ No Division of Vital al or Attending Physician: The sefer death.

I Director: After this certificated in by the funeral director, pa 25. Was casa referred to madical exeminer? Be 26. Placa of Daath (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Certification: To 27. Mannar of Deeth 28e. Data of injury (Month, Dey Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturai 5 Pending invastigation 1 Yas 2 No 2 ☐ Accident 3 Suicida 6 Could not be determined 28f. Location (Straet and Number or Rurel Routa Number, City or Town, Stata) 28a. Placa of injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 I Homicida To the Hospital within 24 hours e To the Funeral Completely filled Hospital Medical 29a. Cartifiar Certifying Physicien: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner es steted.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and mannar statad. 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) Dec. 27, 2000 30. Nema and address of person who completed cause of death (Itam 23a) (Type, Print) L.R. MILES, UR-M.D. 57 JACKSON ST MD 21539 LONACONING 31. Dete filed (Month, Day, Year) 32. Registrar's Signatura State DEC 2 9 2000 Registrar

**DHMH 16 Rev 6/95** 

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Dey Year December 21, 2000 **Physician** HELEN GENEVE MANN 1:20 AM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner Coffman Nursing Home Washington County Hagerstown 8. Date of Birth (Month, Dey, Year) Mar. 14,1913 If Under 1 Yeer | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** 1 □ M 2 X F Months Days Hours Min 87 Yrs. 212-38-9060 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Hagerstown MD Washington Co. 1 ☐ Yes 2 No Director r than "natural", or flams 23s or 28s-the Medical Examiner must be notifi 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21742 U.S.A. 1304 Pennsylvania Avenue Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispanic Orlgin? (Specity Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home h and Mental Hygie is marked other t 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Charles Edward Weigand Virgie E. Spessard emit. Pages 1 and 2 should repartment of Health and Man reportant: If Nam 27 is marke 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert Carl Mann/Son 7 Lehigh Avenue, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery Dec.23 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of) Examiner certificate be executed Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown p Division of Vital Records, 24e. Was an autopsy performed? 24b. Were eutopsy findings evailable prior to completion of ceuse of deeth? Completed page 2 1 Yes 2 10 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 Yes 2 LING 0 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Accident 5 Pending 1 Yes 2 No Investigetion eral Diractor: A 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A after 4 Homlcide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and menner stated. edical 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 2000 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar

DHMH 16 Rev 6/95

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Villiam	Messersmith
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/Medical			rd MESSE		rl			4b. City_Town,		of Death	4c. County		109:00 A.M
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Director	Maryland		ngton		Cle	ear Sp							1 ☐ Yes 2 🏹 No
Dire	10e. Street and N	lumber					10f. Zip Code			10	g. Citizen of \	Whet Cour	ntry?
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Funeral	11. Meritel Stetus		Armed	Decedent Eve d Forces?		13. W	as Decedent of Yes, specify Cub	Hispanic Origin' pen, Mexican, P	? (Specify Yourdon, Rican,	es or No- etc.)		ck, White,	etc.
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	19e. Informant's	Neme/Reletions	ship (Type, Print)		1	9b. Mailing	Address (Stree	t end Number o	r Rural Rout	te Number,	City or Town,	Stete, Zip	Code)
	Catherin	ne Messe	ersmith .	- Daug	hter	206	Hager S	treet	Hager	stown	, Mary	land	21740
	20e. Melhod of D		• 🗆		20b. Place ceme	of Dispos	ition (Neme of etory or other ple	ace)	Dat	Θ 2	Oc. Location -	City or To	own, Stete
		2 ☐ Cremetion 5 ☐ Other (S	3 □Removal fr ipecify)	rom Stete			Cemete		12/14/	00 H	Hagerst	own.	Maryland
21. Signeture of Funerel Service Licensee  22. Name end Address of Fecility Minnich Funeral Hom													
	1	col	111/	hum	, a		L5 E. Wi						21740
	23a. Part1. Ente	the disease, or	complications th	nat caused th	ne deeth. D	Do not ente	r the mode of dy	ing, such es car	rdiec or resp	iretory erre	est,		Approximate Intervel Between
Examiner	disease or condi resulting in deeth Sequentially list if any, leeding to	n)	a. <u>A S</u>		ue to (or es		nd mu pence of):	ir	plun njuni s	t to	orce	1	
edicai	Cause (Disease or injury that initiated evants resulting in deeth) Lest Dua to (or as a consequence of):												
Cia	Part II. Other sign	nificant condition	one contributing t	to death but	not resultin	a in the un	darlying cause o	iven in Part I	2	3b. Did tol	bacco usa co	ntribute t	o the cause of death?
Physician/M	l line orga		To the state of th	July but	- Journal	g (1.19 WI)					s 2 No		bably 4 Unknow
by P											Maria Ti		
Completed 1									2	4a. Was er perform		CC ev	ere eutopsy findings reileble prior to empletion of cause deeth?
EO										1 <i>⊠</i> Ye	s 2 No	1,1	Yes 2□ No
60	25. Was case ref	erred to medica	1					26. Place of	Death (Che	ck only one	9)		
To B	examiner?	□ No	Hospital:	I ☐ Inpatient	2 ER	/Outpatient	3 DOA					ner (Speci	<sup>fy)</sup> Scene
Certification:	27. Manner of De 1 Naturel 2 Accident 3 Suicide	5 ☐ Pendir invasti 6 ☐ Could	not be	Hete of Injury Month, Dey Y Loun Cl L-7-2 C	00 41	b. Time of Injury	n	iry at ork? ] Yes 2,2€ No	28d. D e15 p b1 u1	hyxid n t el	winjury occur tect ar	ned Su ned St	bject was ruck with
Pri	4 Homicida	determ	bi	uilding, etc.	(Specify)		et, fectory, office		C	ity or Town	, Stele)   7	09 N	ational PINC
edicai Co	29a. Certifier (Check only one)		ng Physician: To Examiner: On the	the best of r	xeminetion	ige, deeth					use(s) and m	enner as	
Medical Certification	29b. Signature ar	nd title of certifie	r				29c. Licen	sa number		29	9d. Date signe	d (Month,	Day, Year)
	1/1	-111	1 11	1111	15	10	) (	C.M.E.			Decemi	her C	2000
	30. Name end ad	dreas of person	who completed of	cause of dee	th (Hem 23	a) (Type, F	1	J - 0110 EJ 0			Decan	JCI 3	2000
	1 1 1 1 1 1 1 1 1			tent 2			enn Stre	eet, Bal	ltimor	e. Ma	ryland	2120	)1
State	Strp/ 31. Dete filed (M	onth, Dey, Year)	2000	2. Registrar's	-		H			,	7		
		IFI.Z 6	2000	The same		D	ESG 2/	601					

DHMH 16 Rev 6/95

**ORIGINAL** 

CECREDOM MAN DE STATE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of the th Month 2000 December 6:55 mm Airy Mae Murray 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, giva street and number) 4c. County of Deeth Homewood Retirement Center Williamsport Washington | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | OCT 28, 1931 7. Aga (In yrs. last birthday) 9. Birthpiaca (Stata or Foreign 1 M 200 Mary land 69 Yrs. 220-26-2441 Usuai Rasidence of Decedent 10a. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Washington Williamsport Maryland 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue 21795 USA 12. Was Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 220 No If Yes, Give Yaer or Datas: Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Bleck, Whita, etc. 1 Nevar Marriad 2 Married 1 ☐ Yas XXNo Specify: Specify: 3€Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Vice President 12 Banking 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Byers Kenneth Elwood Elva Mae Obitts 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 10 N. Conococheague St. Williamsport, MD Jean J. Forsythe/Sister 20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cramatory or other place) 20c. Location - City or Town, Stete 1 ☑ Buriei 2 ☐ Cramation 3 ☐ Removal from Stata Riverview Cemetery 12-26-00 Williamsport, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 02. Nama and Addrass of Facility Usborne Funeral Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 23a. Part. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Deeth immediete Ceuse (Finei disaasa or condition resuiting in death) Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest Dua to (or es e consequenca of) Dua to (or as a consequenca of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of causa of deeth? 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical examiner? 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Modical Examines must be notified as

Physician/Medical p

physician and the buriel-transit ed by the attending detached for use as been signed by should be detac funeral director,

Completed Certification: To

27. Menner of Deeth

Medical

1 Naturei

2 ☐ Accident

3 Suicide

29e. Certifier

4 Homicide

29b. Signeture and title of conflict

death. or Attend after death Director: To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th

> State Registrar

28a. Dete of Injury (Month, Day Year)

5 Pending Investigation

6 Could not be determined

mon who completed causa of daeth (Item 23e) (Type, Print)

28b. Tima of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. Licanse number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Tyes 2 No

28c. Injury et Work?

To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.

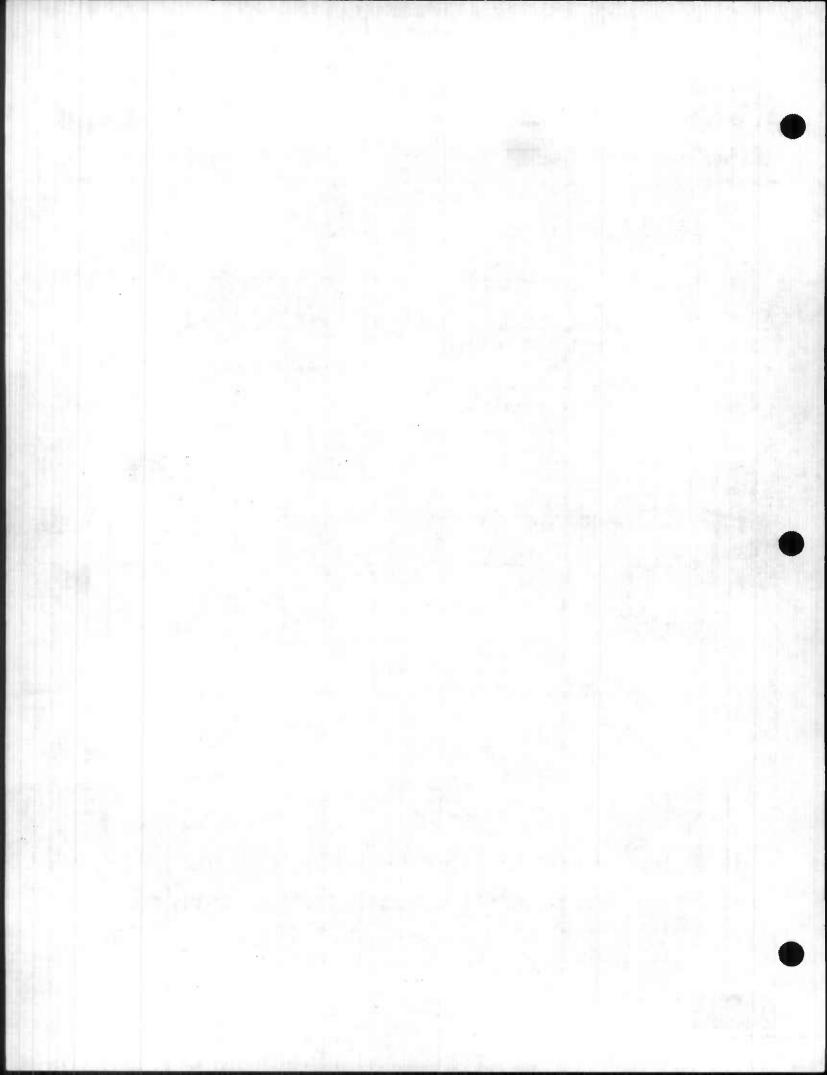
Medical Examiner: On the basis of examination end/or invastigetion, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted.

many of many source of stands

5.00

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 4 2 6 8 4

t Murphy					Ce	rtificat	e of	Death		Reg. No.		
Dhombala		a Name (First, Midd	lle, Last)	THE E					2. Date of D	Peath Day	Yeer	3. Time of Death
Physicia /Medica	Scott	N. Murph							Decem	ber 02,	2000	10:17 P.M
Examine	4a Facility N		on, give street and n					4b. City, Town, or			ty of Death	
			Maryland				1 Voor	Baltin		- 71	/A	
Funeral Director	212-9	8-3778	6. Sex 1 M 2 □ F	19	last birthday) Yrs.	Months	Deys	Hours Min		28, 198	1 Mary	place (Stete or Foreign htry) Land
M g And	10a. Stete	10b. Count	/	10c. C	ity, Town or Lo	ocation	92.				1	Od. Inside City Limits
or 28a-f show be notified at	Maryla	nd Frede	rick	Fr	ederic	k						1 ☐ Yes 🍇 No
9 28 P	Maryla 10a. Street a					10f. Zip	Code			10g. Citizen o	What Cou	ntry?
23s d	6635	Ford Roa	d				21	702		United	State	es
036 ours after dos our, or items Examiner m	3 □ Wido	latus r Merried 2 ☐ Me wed 4 ☐ Divorce	Armed F	12. Was Decedent Ever in U,S. Armed Forces?  1 ☐ Yes 2 ☒ No 1f Yes, Give Yeer or Dates:  13. Wes Decedent II Yes, specify (  1 ☐ Yes 2 ☒ ☐					Specify Yes or Note Rican, etc.)	-20	ack, White,	etc.
Maryland 21215-0036 of 2 should be fised within 72 hours at the and Merical Hygiene. T'is merical other than "natural", or bearrable event, the Medical Exam	Elamentar	15. Decede (Specify only high y/Secondary (0-12) 12	nt's Education est grade completed College	) (1-4or 5+)	16a. Decedent's Usuel Occupation (Give kind of work done during most of life. DO NOT use retired)			pation during most of wo d)	orking	16b. Kind of		
district d		Name (First, Middle	Last)		tarı	mer_		18. Mother's Na	me (First, Midd	le, Maiden Sume		1
ld be left be ked o	Char	Charles Eugene Murphy						Mary V	Irginia	Smith		
and work with the work of the	-	int's Name/Ralation									n, State, Zij	Code)
- 5247	Mary 1	Murphy /	mother		6635	Ford	Roa	d, Frede	rick, M	D 2170	2	13
Ore The State of t		ol Disposition	• CD	20b.	Place of Disponentery, cre				Date	20c. Location	- City or To	own, State
Page Page ment: If		ation 5 ☐ Other (	3 □Removal from Specify)	1 State	. Oliv				12/7/00	Freder	ick, N	Maryland
Baltimore permit. Pages 1 a Department of He Important: If item say injury or othe ons	21. Signetur	21. Signeture of Funeral Service Licensee  22. Name and Address of Facility Stauffer Funeral Homes, P.A.  1621 Opossumtown Pike, Frederick, MD 21702  23a. Part 1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory agrest, interval Between the relatives.										s, P.A.
6876(	resulting in c	ondition death)  list conditions, go to immediate r Underlying ase or injury events	a b	Due to (	e Injur (or es e conse (or es e conse or es e conse	quence of): quence of):	ith	Complica	ations/	Super Lawrence		Onsat and Death
death cer e attendin	Part II. Other	significant condit	d	death but not re	sulting in the u	underlying c	ause gi	ven in Part I.	23b. DI	d tobacco use o	contribute t	o the cause of death?
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Recor	Completed by								App	as an autopsy domed?  Proval.	av ol	lera autopsy findings vailable prior to ompletion of cause daath?  Yes 2 No
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Of Vita Physician: this certific ral director,		2 No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DC	DA Ot	her: 4 Nursing		sidence 6 🗆 C		
o La Parth neral neral			28a. Date	ol Injury nth, Dey Year)	28b. Time o	ol 2	28c. Inju Wo	ry at	28d. Describ	e how injury occ	urred St	ubject was
SiO endir or: Al	2 Acci	dent inves	tigation 11-0	6-2000	9:03	P M	1	Yes 2 No	COLLIC	ed with	trac	nicle which tor-trailer
Division of To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	27. Manner of 1 Natu 2 Acci	doton	minad 200. Pl80	e of Injury - At I ding, etc. (Spec	ify)	treet, factory oadway			28f. Location City or 1 Shock1	(Street end Nut Town, State) B ey Drive	nber or Rui ICKEVST	al Routa Number, own Pike and erick, MD
Hospi 24 hou Funer stely fil	29a. Cartifier (Check of one)		ng Physician: To the Examiner: On the	a best of my kn basis of examin nner stated.	owledge, daat ation end/or in	th occurred nvestigation	at tha ti	ma, data and place opinion, deeth occ	ce, and dua to the curred at the time	e causa(s) and e, date and plac	manner as : e, and due !	stated. to the cause(s)
o the other	29b. Signatu	re and title of Sentili		mor stateu.		290	c. Licen:	se number		29d. Date sig	ned (Month,	Dey, Year)
F 3 F 8	1	hull (	Vy	- KaD			1)4	10384	)	Decemb		
		d address of person 11 Cooper	who completed cer				reet	, Baltin	nore. Ma	ryland	21201	
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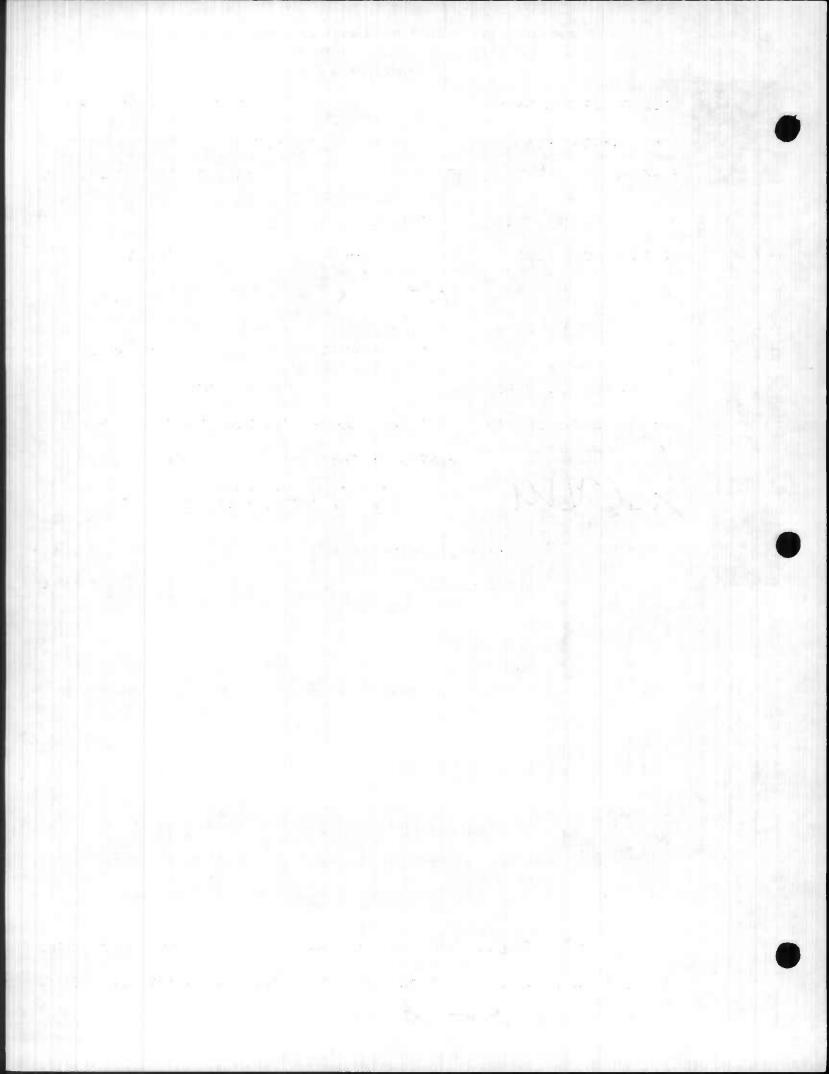
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Examiner		4e Facility Neme (If not institution, give street and number)								ocation of Dee	tri 40	. County			
		18610 WASCHE ROAD  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1					If Under 1 Ye		DICKER Under 24 Hrs.		irth		TGOM		te or Foreign
Funeral Director		217-42-	1	M 2□ F	56	Yrs.	Months De		lours Min.	8. Date of B (Month, D	ay, Yeer 2 19	944		H.	te or Foreign
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ter death with the Marylan forms 23a or 28a-f show free must be notified at	-			MEDV								"		es 2 No	
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MIL N				ROAD			2084					J.S.			
death	Funeral	11. Meritel Status		12. Was Deceden	t Ever in U,S.	13. \	Vas Decedent of f Yes, specify C		nlc Origin? (S	pecify Yes or N		14. Rec	e - America		
urs at	by		rried 2 Merried	Amed Forces?  1 N Yes 2 No 1963- If Yes, Give Year or Dates: 1972				fexican, Puert	o Rican, etc.)		Specify	k, White, 6 WH	etc. ITE		
natural;	ted	/Sn	15. Decedent's Ed	ducation 16a. I		16a. Deced	Sa. Decedent's Usual Occupation (Give kind of work done during most of work		kina	16b. I	Kind of Bu	isiness/ind	lustry	1112	
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Man Marke arke	10		WOODROV			MAMIE MATILDA NEIL  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zi									
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			5 Other (Specif)		KES		EN CEN			12/9	FF	KEDE	RICK	, M	ע
Departr Imports any Inju		1/1	100	11		Н	ILTON	FUI	VERAL						
		23a. Part1. Enter	the disease, or comp	olications that cause	ed the death.		OX 86, er the mode of				MD arrest,	20	838	Approxi	mate
Physician		shock, or he	art failure. List only	one cause on each	line.								1	Interval Onset a	Between nd Death
/Medical Examiner		Immediate Cause disease or condit resulting in death	ion	a. METAS			CINOMA	1						9 m	onths
	ner			CANCE		juence or):						1	9 m	onths	
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2 S	Completed													mpletion death?	of cause
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dling i h. Aftar funar	tlon	1 Naturel	5 Pending investigation	28a. Date of In (Month, D	ey Year)	8b. Time of Injury		njury at Work? I □ Yes	2 🗆 No	200. Describe	s now my	ury occur	160		
I or Attending after death. Director: After d in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not be	28e. Placa of in	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			Number,				
To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After compietaly filled in by the funer	edicai C	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	ysician: To the best liner: On the basis end manner s	of examination	edge, deeth n and/or inv	occurred et the restigation, in m	e time,	dete end plece on, death occu	o, end due to the	e cause( e, date er	s) end ma	anner as st end due to	lated.	se(s)
vithin To the	Me	29b. Signeture en	d title of certifier				29c. Lic	ense nu	ımber		29d. D	ate signe	d (Month,	Day, Yea	ır)
->-0			E.P.	Libre	5 17.	D	DO	94	70	700	DE	CEME	BER 7	7, 2	2000
		30. Name and address of person who completed cause of death (Item 23e) (Type, Print)													

State Registrar EUGENE P. LIBRE, MD 10400 CONNECTICUT AVE., KENSINGTON, MD

31. Dete filed (Month, Day, Year)

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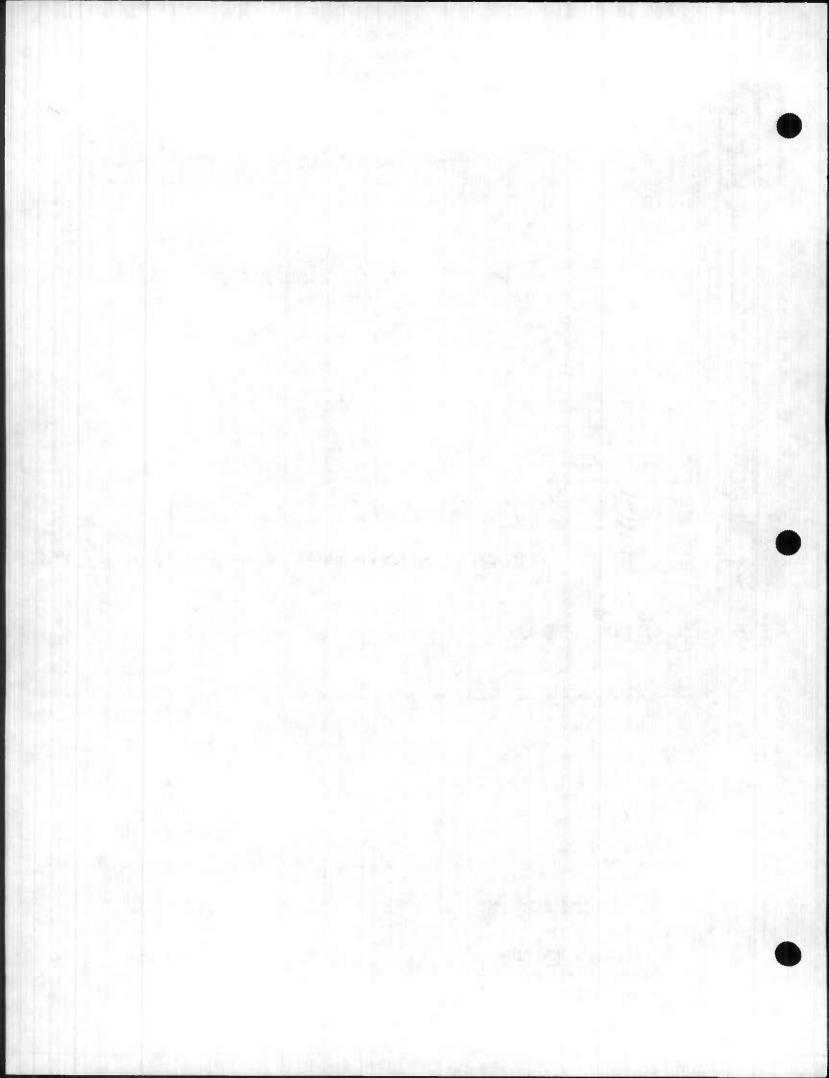
32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 12686

	Grit T			Certificate			Reg. No.			
	Physician	Decedent's Neme (First, Middle, Last)	Marsha Lyn			2. Date of Dea Month	Dey	Year	3. Time of Death	
	/Medical	4e Fecility Neme (If not institution, give stre	Decembe			7:35pm				
	Examiner	9009 Kimblehunt Dri	asville Montgomery			oru				
	Funeral	5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Yeer If Under 24 Hrs					Birth 9. Birthplece (State or Foreign Country)			
	Director	186-42-8666 1□ M	<sup>2</sup> ₩ F 46	Yrs. Months D	eys Hours Min.	May 15,	1954 I		ylvania	
	yland	10a. Stete 10b. County	THE		10	d. Inside City Limits				
	e Mer	Maryland Montgomer	y La	ytonsville_		A. C.			1 ☐ Yes 2 1 No	
	ith the Me or 28s-1 s	10e. Street and Number		10f. Zip Co	de	10g. Citizen of What Country?			ry?	
	ath w	9009 Kimblehunt Driv				United				
Maryland 21215-0020	72 hours after death with the Meryland netural; or thems 23s or 28s-f show seel Example to make a nothing a steel by Furneral Director	11. Meritel Stetus  1 Never Merried 2 Merried  3 Widowed 4 Divorced	Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:	S. 13. Was Decedent If Yes, specify	of Hispenic Origin? (S) Cuben, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)		- America , White, e		
2-0	ed within 72 hours ygiene. or then "netural", rt, pre Westerley, Completed by	15. Decedent's Educat (Specify only highest grade of		16e. Decedent's Usual O	kina	16b. Kind of Bus	siness/Ind	ustry		
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and	SES W	17. Father's Neme (First, Middle, Last)			18. Mother's Neme (First, Middle, Maiden Surname)					
Z	should be and Mental marked umatic ev	Albert S. Brenneman  19e. Informent's Neme/Relationship (Type,	Print)	19b. Meiling Address (S.	Emily M		or City or Town 5	State Zin	Code)	
Z		J. Richard Monarch/								
Baltimore,	of He	20a. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Rem	20b. F	Plece of Disposition (Name emetery, crematory or other	of	Date	20c. Location - C			
tim	nit. Peg artment ortant: It Injury o	4 Donetion 5 Other (Specify)	Met	ropolitan Cr		2/11/00	Alexandi	cia,	Virginia	
Ba	permit. Peg Department Important: It any Injury o	21. Signature of Funeral Service Licensee	Sinen	Olin L.	ddress of Fecility Molesworth dge Road, I				20872	
	Physician	23a. Pert1. Enfer the diseese, or complicat shock, or heert feilure. List only one					4		Approximete Intervel Between Onset end Death	
Medical Examiner Immediate Cause (Final disease or condition resulting in deeth)  Immediate Cause (Final disease or condition resulting in deeth)  Due to (or es a consequence of):							THE AND	No	2/24EARS	
	icete be executed physician and s the burial-transit	Sequentially list conditions,	Due to (a	r es e consequence of):				1		
60,	lcian de burial	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infilteded events								
-	0 f 5 TO	resulting in death) Last  Due to (or es e consequence of):  d.								
Box	death certi									
۵.	that the death certified by the ettending deteched for use by Physician/M	Pert II. Other significant conditions contrib	outing to death but not res	ulting in the underlying caus	e given in Pert I.	23b. Did tobacco use contribute to the cause of death?  1 Yes 70 No 3 Probably 4 Unknown				
Records,	The law requires that the death certific atte has been signed by the ettending page 2 should be deteched for use as Completed by Physician/Mex						en eutopsy med?	976	ore eutopsy findings bilable prior to appletion of cause	
Sec	has b							of c	leeth?	
	cate ha			TO ASSET IN		101	res 20 No	1 🗆	Yes 2 No	
Ħ	Physician: The this certificate ral director, page Co.: To Be Co.	25. Wes case referred to medical examiner?	pitel:		Other:	th (Check only o				
o	E E =	1 1 1 4 S 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	28a. Date of Injury	ER/Outpatient 3□ DOA 28b. Time of 28c.	Injury et Work?		dence 6 Othe		"	
O	Attanding Phor death.  actor: After the by the funeral	1 Neturel 5 Pending investigation	(Month, Day Year)	Injury	Work? 1 ☐ Yes 2 ☐ No					
-	tal or Attanding P rs after death. al Director: After t ed in by the funera Certification:	a Could not be	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory, o	fice	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attank within 24 hours after deati To the Funeral Director: completely filled in by the Medical Certifical	29a. Cartifier 1 Certifying Physici (Check only 2 Medical Examiner	: On the basis of examine	wledge, death occurred at t tion end/or investigation, in	he time, date and place my opinion, death occu	, and due to the rred at the time,	ceuse(s) and mar date and place, a	nner as st and due to	ated. the cause(s)	
	within 2 To the comple	and menner stated.  29c. License number  29d. Dete signed (Month, Day, Year)								
	- 5 - ō	Deme G. Brown Min DO72RT DECEMBER 11, 2000							, 2000	
			30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)							
	State	James A. Brown M. D 31. Dete filed (Month, Day, Year)	32. Registrar's Signe	ical Center I	rive, Rock	ville, N	laryland	20	0850	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $\mathbb{U}$   $\mathbb{U}$ Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear MADDOX MAGGIE December 12,2000 5:30 A.M. 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death View Nursing Center College Frederick Frederick It Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dev. Year) 6. Sex 1□M 200 F Months Days Hours Yrs. 218-66-1409 83 April 3, 1917 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1848 Millstream Drive 21701 United States 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maddox Ernest W. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620-B, Research Dr./ Frederick, Maryland 21703 Susan B. Holton / friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete
4 ☐ Donation 5 ☐ Other (Specify) 12-13-00 Hagerstown, Maryland Hagerstown Crematory 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licenses Loymonc, 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part office the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy tindings 24a. Was an autopsy

Physician /Medical Examiner

and

after death.

Director: After this certificate has been signed by the a in by the funeral director, page 2 should be detached f

Be Completed by

Certification: To

Medicai

The law requires that the death certificate be executed

or Attending Physician:

Division of Vitai Records, P.O. Box 68760,

Department of Health a Important: If Item 27 is any injury or other trau

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Physician

/Medical

Examiner

10a. Stete

Directo

Funeral

by

Completed

Be

**Funeral** 

Director

"natural", or items 23s or 28s-f ahov

Ahygiene. other than "natural", or items 23s or went, the Medical Examiner must be

filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

art II. Other significant conditions	contributing to death but	t not resulting in the underly	ing cause given in Part
Hypertens	con.		
Consestive		Failure	with
Moderate			
5 Was case referred to medical			26 Place

Hospital:

-		completion of cause of death?
)	1 □ Yes 2 No	1 ☐ Yes 2 ☐ No
e of Death	(Check only one)	

examiner?	lo
27. Manner of Death	5 □ Panding

1 Inpatient 2 ER/Outpatient 28a. Date of Injury 28b. Time of

3 🗆 (	DOA	Otner:	4 Nursing H	5[	
	28c.	Injury at Work?		28d.	De

Н	ome	5 Residence	6	Other	(Specify)
	28d.	Describe how inj	ury	occurred	

2 Accident	5 Pending investigation	(MOHIII, Day Year)	M	10
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, ferm, street, tacto	ory, office

		280. Descri
S	2□No	

28t.	Location (Street and Number or Rural F	Poute Number

29a.	Certifier
	(Check only
	one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

1 ☐ Ye

<b>&gt;</b>	Sd	1 11	enu	_	
30. Name	and address of	person who	completed cause	ot death (Item 23a) (Type, Print	()

29c. License number

29d. Date signed (Month, Day, Year)

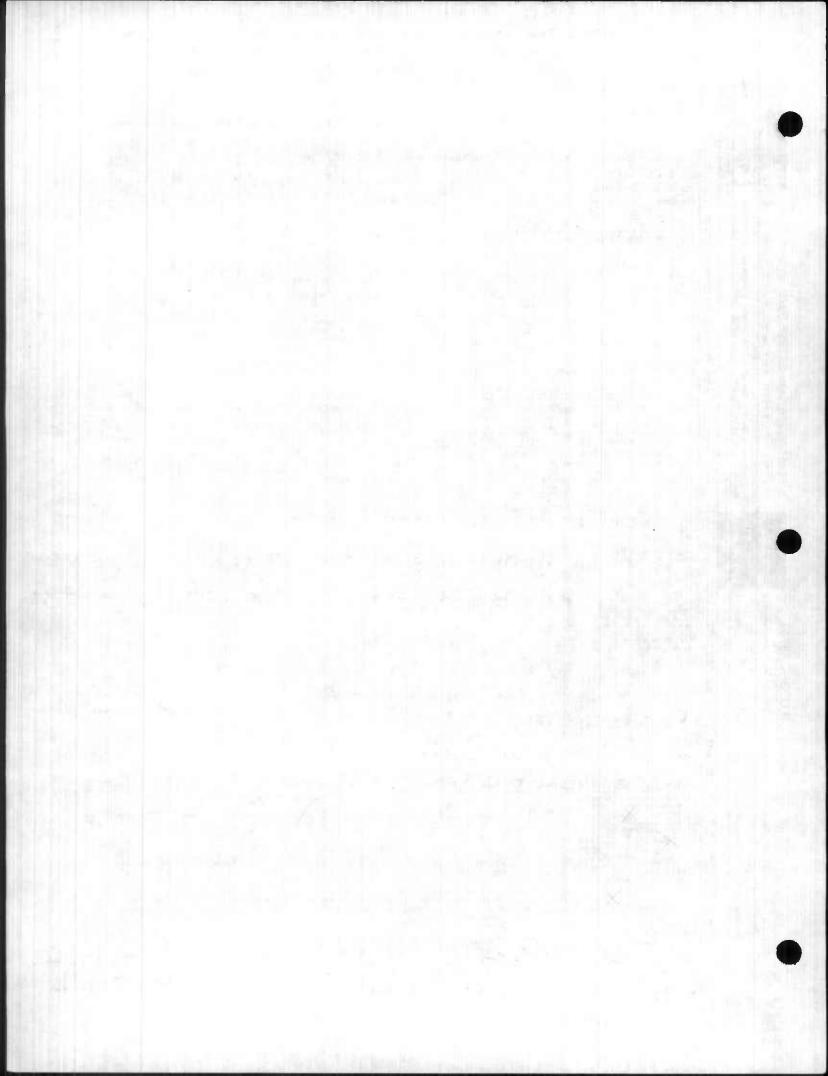
State Registrar

completely filled in by

To the Hospital within 24 hours a To the Funeral D

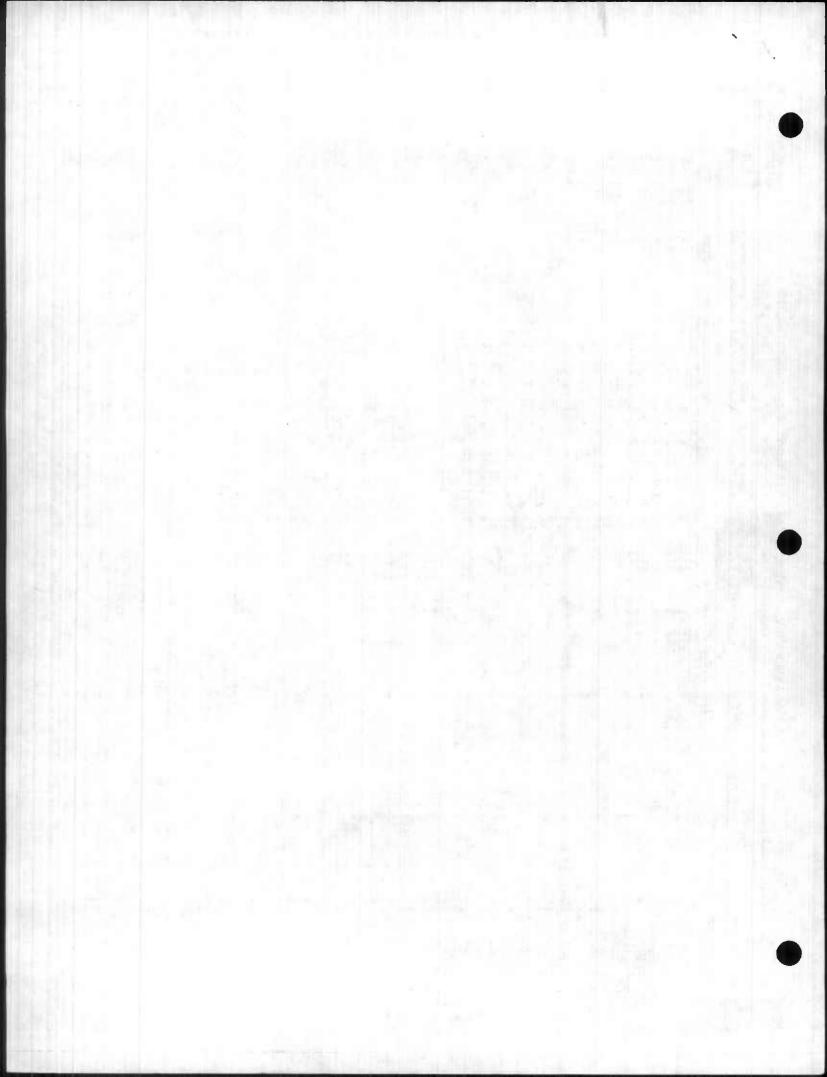
1475 am 31. Dete tiled (Month, Day, Year) 32. Registrar's Signature 4 2000 ▶

trederick. Taney Ave



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

			Amended item#19a	12/22/2000 FCH					Reg. No.	-7	2000
	Dhysisian	1	. Decedent's Name (First, Middle, Las	()				2. Date of Dea		Year	3. Time of Death
100	Physician /Medical	L		Matson Mohle	r			Decemb	er 15, 2		8:45 AM
	Examine		a Facility Name (If not institution, give Frederick Heal		r		4b. City, Town, or Lo Freder		4c. County of		k
	Funeral Director		212-14-03/3	7. Age (In yrs. I	last birthday) Yrs.	If Undar 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da July 7	, Y1910 1	9. Birthpi Mary	lace (State or Foreign Land
	Bud &	-	Usual Residence of Decedent  10a. State  10b. County	10c. City	, Town or Loc	cation				1	Od. Inside City Limits
	Maryd H aho	5	Maryland Frederi	.ck Po	oint of	f Rocks					1□ Yes 2No
	h with the Ma 23a or 28a-fa be nouthed	1	Oe. Street and Number 4118 B Tuscaror	a Road		10f. Zip Code 2177	7		10g. Citizen of W U.S.A		fry?
21215-0020	within 72 hours after death with the Maryland she, than 'natural', or items 23s or 28s-f show he Medical Exemines must be notified as	2	Marital Status     Never Married 2 Married     Widowed 4 Divorced	12. Was Decedent Ever In U, Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates;	H	Vas Decedent of I Yas, specify Cub ☐ Yes ②☐ No	dispanic Origin? (Sp an, Maxican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	- America k, White, k	
5-0	natural',		15. Decedent's Ed	ucation de completed)	16a. Deced (Give)	ent's Usual Occup	pation during most of work d)	ing	16b. Kind of Bus	iness/Ind	lustry
121	ed within 72 ho ygiene. er then "natur ft, pre Mexical		Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retire ck Hand	d)		Railroa	đ	
	Hydra A		7. Father's Name (First, Middle, Last)		IIa	on mana	18. Mother's Nam	e (First, Middle,			
lan	Sabs q	0		rwood Mohler,	Sr.		Nelli	e Dor	cus Kli	pp	
, Maryland	nd 2 she lith and 27 is m		19a. Informant's Name/Relationship (7 Mr. Thomas L. Moh	<sub>ype, Print)</sub> Grandson iler, Uncle	19b. Mailin 16 I	g Address (Street Hamilton	Ave., Fr	ederick	er, City or Town, S , Maryla	nd 2	£701
Baltimore,	8 5 5 0	2	0a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	ematery crem	sition (Nama of natory or other pla et Cemeter	y, Dec. 18,	Date 2000	20c. Location - C		wn, Stata Maryland
Balt	permit. Page Department of Important: If any Injury or ance.	1	21. Signature of Funeral Service Licente	MA / MO0255	K		d Basford				21.701
9	Physician		23a. Part1. Enfer tha disaasa, or comp shock, or heart failure. List only of	one cause on each line.						1	Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. CONO	estiv	E MEA	AT FA	CURE		1	1 mouth Syears
		5		Aptolo	ENLOS	uence of):	ric CAn	DISUAS	ultr	1	Surars
	cate be executed physician and s the bunial-transit	100	Sequentially list conditions,	b. Due to (o	r as a consequ	uence of):		1971	Dise	ASO	
68760,			Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C							
	eath certificate be attending physicis		resulting in death) Last	Dua to (or as a consequence of):							
Box	atten d for u		Part II Other algolds ant appditions of	antellection to double but and can	ilian la tha	alah ina ayan si	uan la Darit I	22h Did	lohenno use non	enlbure er	the cause of death?
P.O.	es that the death certification of the death of the attending be detached for use as by Dhyel-lan/Me		Part fl. Other significant conditions co	intributing to death but not rest	alling in the or	idenying cause gr				bably 4 Unknown	
Records,	requir							24a. Was perfo	an autopsy rmed?	co	ere autopsy findings allable prior to mpletion of causa death?
	The law ate has be page 2 s							10	Yes 25 No	10	☐Yes 2☐ No
/ita	ysician: The s certificate director, pag	2	25. Was case referred to medical examiner?	11			26. Place of Dea	th (Check only o	one)		
n of Vital	Pis di		27. Manner of Death  1 SNatural 5 Pending	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	ry at rk?		denca 6 Othe how injury occurre		y)
Division	Attended or deat by the		2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre		Yes 2□No	281. Location (City or Ton	Street and Number vn, State)	er or Aure	I Route Number,
	To the Hospital or Attentwithin 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	/sician: To the best of my knowiner: On the basis of examination and manner stated.	wledge, death tion and/or inv	occurred at the ti	me, date and place, opinion, daath occur	and due to the red at tha time,	cause(s) and mad date and place, a	nner as s	tated. ofhe cause(s)
	To the complete compl		29b. Signature and title of certifiar		1751	29c. Lican	se number		29d. Date signed	(Month,	Day, Year)
			1 & Wille	w MD		D	2203	7	12/	15/2	2000
		3	10. Nama and address of person who c	completed cause of death (Itam	23a) (Type, I	Print)			ick , r	1)	
	State Registrar	3	B1. Date filed (Month, Day, Year) DEC 1 8	32. Registrar's Signa	ture	4 dos	ue B				



Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Heath and Mental Hypises. Important: If from 27 is marked other than "natural", or flerie 23s or 23s-f show any highey or other traumatic event, the Medical Examiner must be notified at other.

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

		,
State of Maryland /	Department of Health and Mental Hygiene	

shall		State	of Marylan		artment of	Health and			42	689
1. Decedent's Nam	e (First, Midd	le Last)	12.00	001	imouto o	Doutt	2. Dete of De	Reg. No.	100	3. Time of Death
1. Dooddin a reali	o (i iisi, iiiisa		1 01				Month	Dey	Year	
4. Frankis Name (	66 4 2 424 - 42 -		d Glenn	Marsh	all	4b. City, Town, or	December of Deat		2000	12:12 P.M
		n, give street and nu		. 7					ty of Death	
		ck Memoria			If Under 1 Yea	Frede			reder:	
5. Sociel Security N		6. Sex 1☑ M 2□ F	7. Age (in yrs.	Yrs.	Months Dey		. (Month, De			place (Stete or Foreign
213-50-84 Usuel Residence of			42	113.			Aug.18	1958	Ma	ryland
10a. State	10b. County	,	10c. Cit	y, Town or Lo	cation				11	Od. Inside City Limits
36 7 1										1 ☐ Yes 2X No
Maryland  10e. Street and Nu		derick	Fr	ederic	10f. Zip Cods			10g. Citizen of	Mhat Cou	ate 2
					Tot. Zip Coda			Tog. Citizen of	Whet Con	my r
6672 Seag	gull Co				11 10	21703	- 7 V N	United		
11. Merital Status		Armed F		S. 13. Y	Was Decedent of f Yes, specify Cu	f Hispanic Origin? ( uben, Mexican, Puer	Specify Yes or No rto Rican, etc.)	0- 14. HG	ace - Americ ack, White,	
1 Never Merr		If Yes, G			1 ☐ Yes 2 ☒ N	o Specity:		Spec	ify:	
3 Widowed			Dates:						Whi	
(Spec		nt's Education est grade completed,		(Give	lant's Usuel Occ kind of work don	e during most of wo	orking	16b. Kind of	Business/In	dustry
Elamentery/Seco	ondary (0-12)	College	(1-4or 5+)		DO NOT use reti					
				L.	ineman :	Supervisor			viati	on
17. Father's Nema	(r:rst, Middle,	LAST)				18. Mother's Na	ame (First, Middle	, maiden Suma	ime)	
George J.	Marsh	a11				Joan E	dwards			
19e. Informent's N	eme/Reletions	ship (Type, Print)		19b. Maitin	ng Address (Stre	et and Number or F	Rural Route Numb	per, City or Tow	n, Stata, Zip	Code)
George J.	Marsh	all/ Fath	er	505	Logan St	treet, Fr	ederick,	Maryla	nd 21	701
20e. Method of Dis 1   Burial 2 4 □ Donetlon	Cramation	3 ☐Removel from Specify)	Stata	emetery, cran	sition (Neme of netary or other p rg Metho	odist Cem	Dete	20c. Location		Maryland
21. Signeture of Fu	ineral Service	Licensee	,	0.	Neme end Add	dress of Fecility Moleswort dge Road,	h P. A. Damascu	Funeral	. Home	20872
23a. Pert1. Enter t	he diseese, o	r complications thet t only one cause on	caused the deat						1	Approximete Intervel Between
Immediete Causa disease or condition resulting in deeth)	(Final	a	ompre	2SS10	nal	Asp	hyx	ia	1	Onset and Deeth
Sequentially list co	nditions,	b	Due to (o	r as a conseq	juence of):				i 	
Sequentially list co if any, teeding to in cause. Enter Unde Ceuse (Disease or	erlying									
that initiated events rasulting in death)	8		Due to (or es e consequence of):							
		0.						. 13.11	1	Bridge Inc.
Part II. Other signif	licant conditi	ons contributing to d	leeth but not res	ulting in the u	nderlying cause	given in Pert I.		Yes 2 No		o the causs of death? bably 4 Unknown
			10.1				24a. Was	s an autopsy ormed?	ev cc	dere eutopsy findings raileble prior to empletion of cause deeth?
							10	Yes 2□No	1	Yes 2 No
25. Was case refer	red to medica	N N				26 Place of D	eeth (Check only			
examiner?		Hospitel:	Itanatian OT	ED/O		Where			When (Consi	4.1
27. Menner of Deat  1 Natural  2 Accidant	h 5 🗆 Pendii invest	ng 28e. Date (No igation )2 /	-	28b. Time of Injury	Found to in	ijury et Vork? Yas 2 No	Home 5 Res	how jajury occ		Between dumoster
3 ☐ Suicide 4 ☐ Homicida	6 Could detarn	nined Paulo	e of Injury - At he ling, atc. (Specifi King	Lot,	Airp	ort	City or To	(Street end Nur own, State)	rick	Md
29a. Cartifier (Check only one)	2 Medical		a best of my uno pasts of exemine oner stated.	wledga, daaft tion and/or inv	vestigation, in m	y opinion, daath occ	ca, and dua to tha curred at tha time,	, date end plec	a, and due t	o the cause(s)
29b. Signature and	tilleyof cartifie	or A	A	1 0	29c. Lice	ense number		29d. Date sign	ned (Month,	Dey, Year)
14	Te	Alane	~ 1	(-D	0	.C.M.E.		Dece	mber	19, 2000

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

within 24 hours after death.

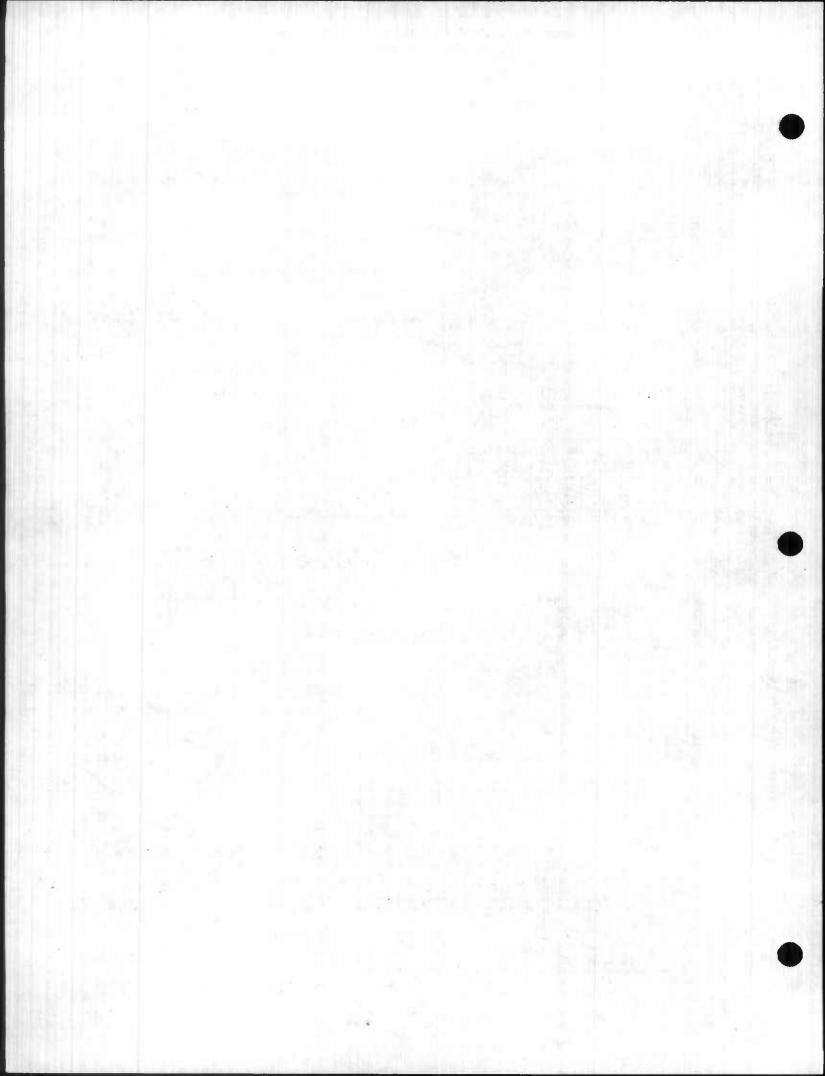
To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be avacuted Division of Vital Records, P.O. Box 68760,

31. Determed Month, Day, Year DEC 2 2 2000

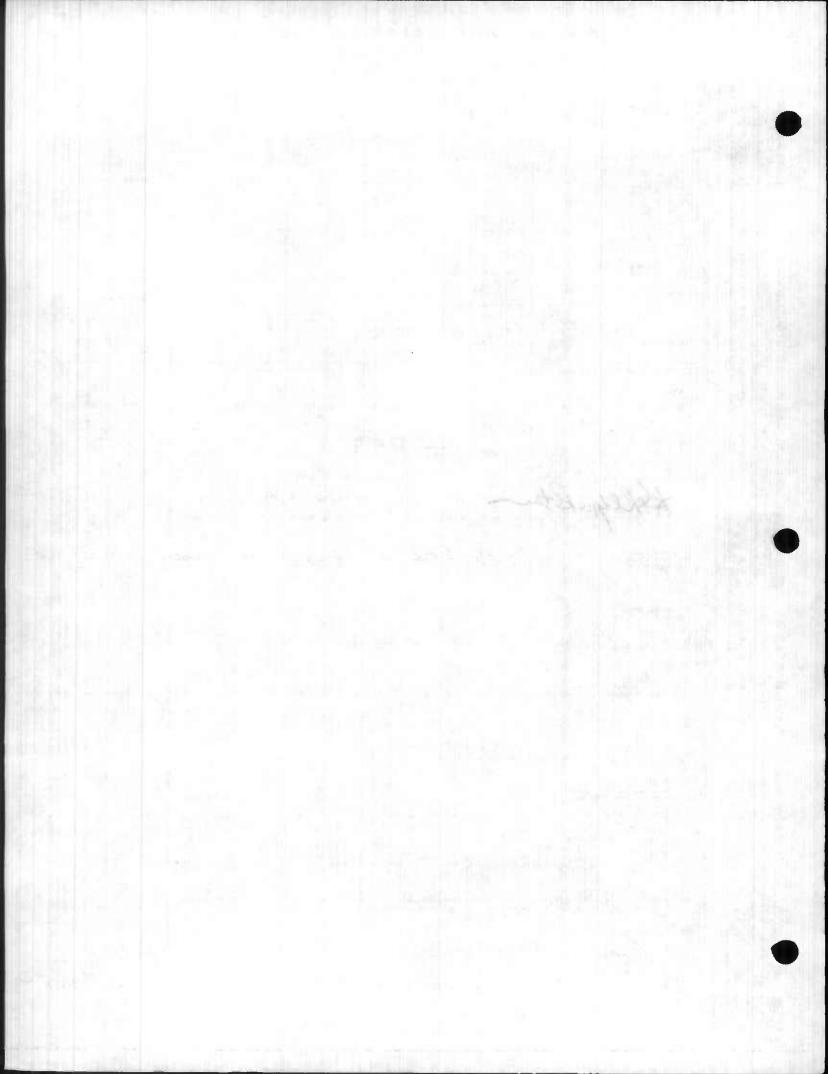
30. Name and address of person who completed causa of death (Itam 23a) (Type, Print)

restaner 111 Penn Street, Baltimore, Maryland 21201 32 Registrar's Signature

DHMH 16 Rev 6/95



		State of Maryla	and / Department of Certificate of	Health and Mental F Death	Hygiene U U	42030			
	1. Decedent's Nama (First, Middle, Las	t)		2. Date of		3. Tima of Death			
Physician /Medical Examiner	William Mack Moor			Month Decen 4b. City, Town, or Location of De	nber 19, 20				
LAdillile	Vindobona Nursing	Home		Braddock Heigh	nts Frederi	ck County			
Funeral	Social Security Number     6. Security Number	7. Age (In yr	s. last birthday) If Undar 1 Yaa Months Days	r If Under 24 Hrs. 8. Date of Hours Min. (Month,	Birth 9.	Birthplace (State or Foreign Country)			
Director	Usual Rasidance of Decedent	8,	7 Yrs. City, Town or Location	Nov.	27, 1913 M	aryland			
show s			ederick			10d. Inside City Limits 1 □XYas 2 □ No			
the N	Maryland Frederic	K CO. FIE	10f. Zip Coda		10g. Citizen of Wha				
urs after death with the Meryland al., or fame 23a or 28a-f show Earth and the Dodlard at the European Director	214 South Market	Street	21701		USA				
death	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13. Was Decedant of	Hispanic Origin? (Specify Yes or ban, Mexican, Puarto Rican, etc.)		American Indian, White, etc.			
n 72 hours after death w natural, or thems 23s	1 Never Married 2 Married	1 ☐ Yes 2 X No	1 ☐ Yes 2 ☐XNo		C				
		Year or Datas:				White			
be filed within 72 ho tel Hygiene. avent, fre then custure event, fre the completed	15. Decedant's Ed (Specify only highest grad	de complated)	16a. Decedant's Usual Occu (Give kind of work done lifa. DO NOT use retin	upation a duning most of working and)	16b. Kind of Busin	ess/industry			
d within 72 hours af giene.  If the factor is then controlled to the factor is the fac	Elementary/Secondary (0-12)	Collega (1-4or 5+)	Executive Vic		Banking				
e filed other other	17. Father's Name (First, Middle, Last)	United to Paris		18. Mother's Name (First, Mid	Idle, Maiden Sumama)	HIM BUSH			
Mentel Me	John Mack Moore			Iva Helen Fis	her				
d 2 should be file th and Mentel Hy 7 is marked othe traumatic svant	19a. Informant's Name/Relationship (7	ype, Print)		et and Number or Rural Route Nu					
2 2 2 2	William M. Moore,	Jr.	214 South Ma	rket Street, Fr	ederick, M	21701			
semit. Peges 1 a Department of Her mportant: If ham ny injury or othe MGB.	20a. Mathod of Disposition 1	Removal from State	cemetery, crematory or other pi	ace) 12/22/					
0 6 5 7	4 Donation 5 Other (Specify	) 111	t. Olivet Cemet	2000		k, Maryland			
permit. Pe Departmen Important: any injury	21. Signature of Funeral Service Licen	ee /	22. Name and Addi	ress of Facility Keeney a	and Basford	Funeral Hom			
002#0	23a. Parl1. Enter the disease, or companies shock, or heart failure. List only of	M0099	99   106 East	Church Street,	Frederick,	Maryland 21			
g physician and es the burial-transit	Cause (Disease or Injury	Due to  Due to	(or as a consequence of):  (or as a consequence of):	slivvasador					
ires thet the death certificate signed by the attending physide detached for use as the dry physician Medical	that initiated events resulting in death) Last  Due to (or as a consequence of):  d.								
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thet the detache detache					1 Yes 20 No 3	Probably 4 Unknow			
required hour					Vas an autopsy performed?	24b. Wara autopsy tindings available prior to completion of cause			
sician: The law requires to certificate has been signed frector, page 2 should be					Yes 2 No	of déath?			
n: Trifficate or, pe				26. Place of Death (Check or		1 162 70 110			
Physician: The I this certificate he ral director, pege		Hospital: 1 Inpatient 2	□ ER/Outpatient 3□ DOA	Other: 4 Nursing Home 5 F		(Specify)			
Attending Physic death.  ector: After this by the funeral di		28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Inj		ibe how injury occurred				
Patra P	3 Suicide 6 Could not be determined	28a. Place of Injury - At building, etc. (Spec	homa, farm, straat, factory, office cify)		on (Streat and Number Town, State)	or Rural Route Number,			
To the Hospital within 24 hours of the Funeral completely filled		vsician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death occurred at the nation and/or invastigation, in my	time, date and place, and dua to opinion, daath occurred at the ti	tha cause(s) and mann ma, data and place, and	ar as stated. I due to the cause(s)			
within 2 To the comple		2011	29c. Licer	nse number	29d. Data signed	Month, Day, Year)			
	Tilld.	Karpon		13971	12/1	9/00			
	30. Name and address of person who of	completed cause of death (It	em 23e) (Type, Print), ederick M	0 21701	Roberth	Kaufmann			
State Registrar	31. Date filed (Month, Day, Year) DEC 2	32. Registrar's Sig	natura &	na V.					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death HARLES Dec. 6. ORRIS EPWARD 2000 10:30 AM 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Glade Valley Nursing and Rehabilition Walkersville Frederick If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) Davs Months 1⊠M 2□ F 220-05-6346 Dec. 29. 1914 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits MD. Frederick 1 Tyes 2 TXNo Middletown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6814 Mt. Church Rd. 21769 U.S.A.

14. Race - American Indien,
Bleck, Whita, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Datas: 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer road construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Green Norris Minnie Powers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgar D. Norris (Son) 6820 Mt. Church Rd., Middletown, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cem. Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 12/9 Middletown, MD. 4 ☐ Donation | □ Other (Specify) Locust Vally Bible Ch. 20 Donald Agress of Feeling Son Funeral Home o of Fur arai Shrvion Mo 31 E. Main St., Middletown, MD. 21769 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Pert1. Enter the disease, or comp shock, or heart feilura. List only of Approximate Interval Between Onset end Death Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 | Yas 2 No 3 | Probably 4 | Unknown 24b. Were autopsy lindings available prior to completion of causa of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yas 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28d. Describe how injury occurred

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Hygiene.

permit. Pages 1 and 2 should be flied w Department of Health and Mental Hygien Important; if hem 27 is marked other the any finjury or other free marked other the

Saltimore, Maryland 21215-0020

Box 68760

Records, P.O.

Division of Vital

must be notified

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Examiner Physician/Medical P Completed Be 9

physician and the buriel-transit attending p signed by t peen has this funeral To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funera Certification: After

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatule and title of cartified 29c. License numbe 29d. Date signed (Month, Day, Year)

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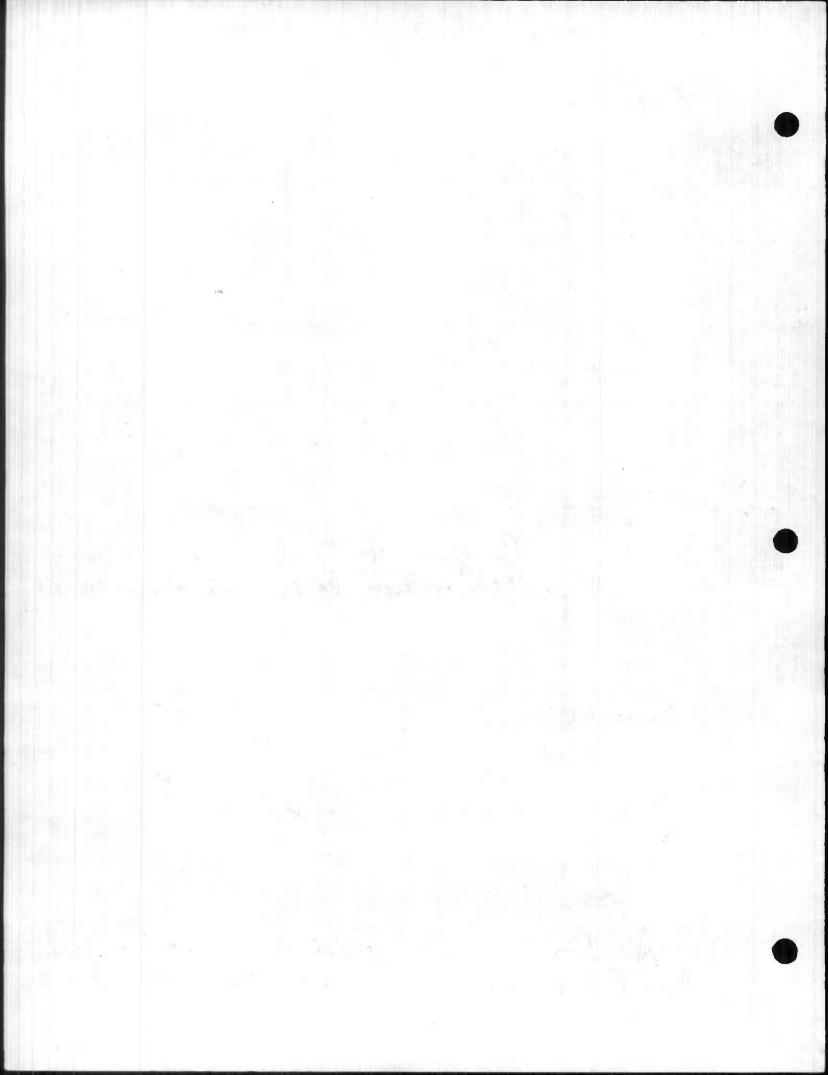
State Registrar

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completed cause of death (Item 23a) (Type, Print)

32. Registrade Signature

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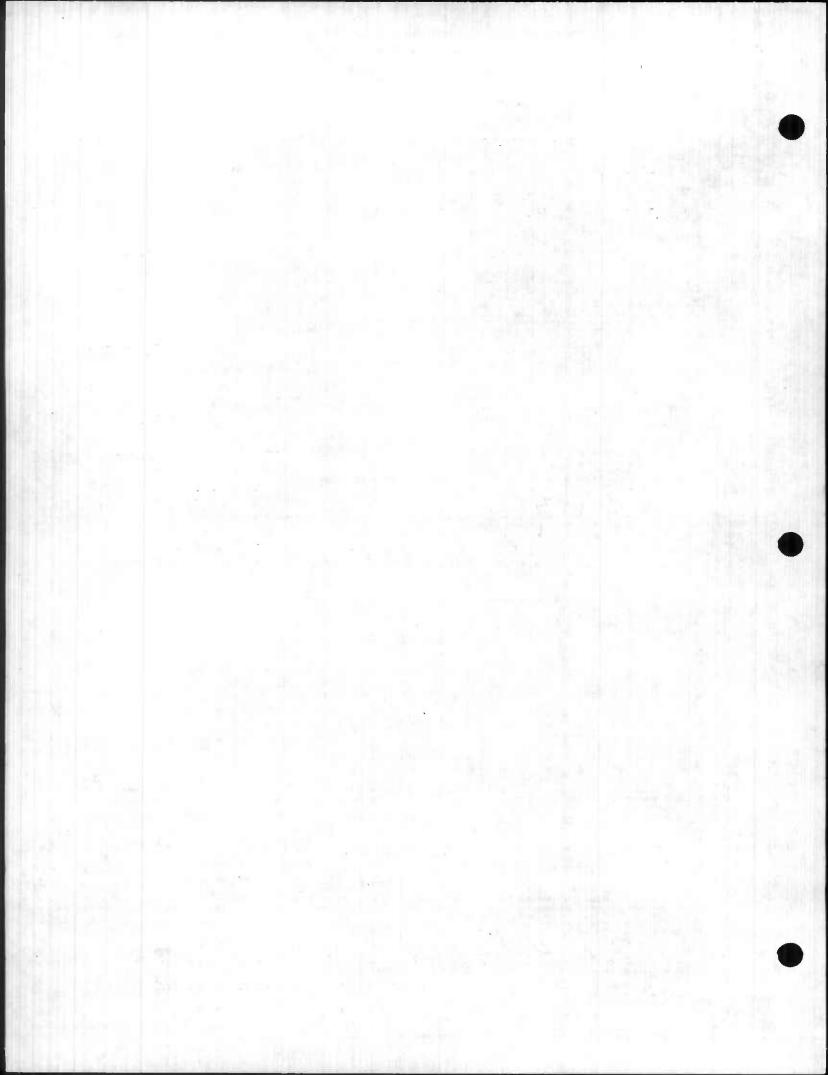


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lip Daniel	Newhard		C	ertificate o	f Death	Re	g. No.		
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Physician /Medical	THEFT DUTTE	Newhard				Decembe		000	08:25 P.M
Examiner	4a English Name // not institution air	va street and number)			4b. City, Town, or L	ocation of Deeth	4c. County of	f Death	
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Maryland f show led at	Usual Residence of Decedent  10e. Stete 10b. County  Maryland Freder	10d. Inside City Limits 1 ☐ Yes 2 🛣 No							
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21215-0 ed within 72 ho rygiene. ser then "neture 4, the Medical.	15. Decedent's E (Specify only highest gr Elementery/Secondery (0-12)	ducation ade completed) College (1-4or 5-	(Gi	cedent's Usuel Occ ve kind of work don DO NOT use reti	upation te during most of work red)	king	Medica		
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Balti pemit. Departri Imports eny inju	21. Signature of Funeral Service Lice	A	100255	22. Name end Add Keeney	and Basfo Church St	rd P.A.	Funeral	Home	e 21.701
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or Attended of the by t	3 Suicida 6 Could not to determined	28e. Plece of Inju building, etc.	ry - At home, ferm, (Specify)	street, factory, offic	80	28f. Location (St City or Town	State) Man	or Pura	I Route Number,
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Division (To the Hospital or Attending P within 24 hours after death. To the Funeral Director After to completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Pl (Check only 2 Medical Examone)	nysician: To the best of miner: On the basis of and manner stat	examinetion end/or	eth occurred at the investigation, in m	time, date end plece y opinion, deeth occu	, end due to the co rred et the time, d	tuse(s) end mai ete end plece, s	nner as st ind due to	ated. the ceuse(s)
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	30. Neme and address of person who	completed ceuse of	(Item 23e) (Typ		x		2304		,
	1 theonoto M.	King	111 Pe	nn Street	, Baltimo	re, Mary	land 21	201	
State	31. Dete filed (Month, Dey, Year)  DFC 1 5	32. Registra	r's Signeture	4 1	aks)				
Registrar	חבר ו פ	2000	The same of	1000	TISS/				

**ORIGINAL** 



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 42693 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Marie Catherine Nee December 13, 2000 action of Death 4c. County of Death 1:25 p.m. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) Examiner Frederick Memorial Hospital Frederick Frederick Hunder 24 Hrs. 8. Dete of Birth (Month Day Year) April 28, 9. Birthplace (State or Foreign Country) Indiana 7. Age (In yrs. last birthday) If Under 1 Yeer **Funeral** Months 1 M 2 F Days 1925 311-30-8482 Director Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Frederick Frederick Director must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8204 Greenvale Drive 21702 U.S.A. Norma 23s Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Merried 2 Married "natural", or 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care - Nursing 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be Department of Heelth and Mental Important: If Item 27 is marked or Maurice Stangle Blanche McCormick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Thomas Nee/Husband 8204 Greenvale Drive, Frederick, Md. 21702 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Specify) Mt. Olivet Cemetery Dec. 18, 2000 Frederick, Maryland 21. Signature of Funeral Servica Licensee 22. Name and Address of Fecility Keeney and Basford Funeral Home 106 East Church Street, Frederick, M00021 Md. 21701 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Final diseese or condition resulting in deeth) SELSIS Examiner Due to (or as e consequenca of): Examiner PERITONITIS TERIAL the death certificate be executed attending physician and for use as the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760 SEVERE CIRRITOSH UNKNOW Physician/Medical Due to (or as a consequence of) ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uas contributs to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown MELLITUS DIABETER ò 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed RENAL FAILURE LUPUS 1 Yes 2 No SYSTERIC ERYTHER ATOSIS 1 Yes 2 No certificata Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Nnpatient 2 EN/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this After this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? or Attending 1 Natural 5 Pending investigation death. 1 Yes 2 No Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homlcide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 1058 HE/EDRIAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar SMITH

2000

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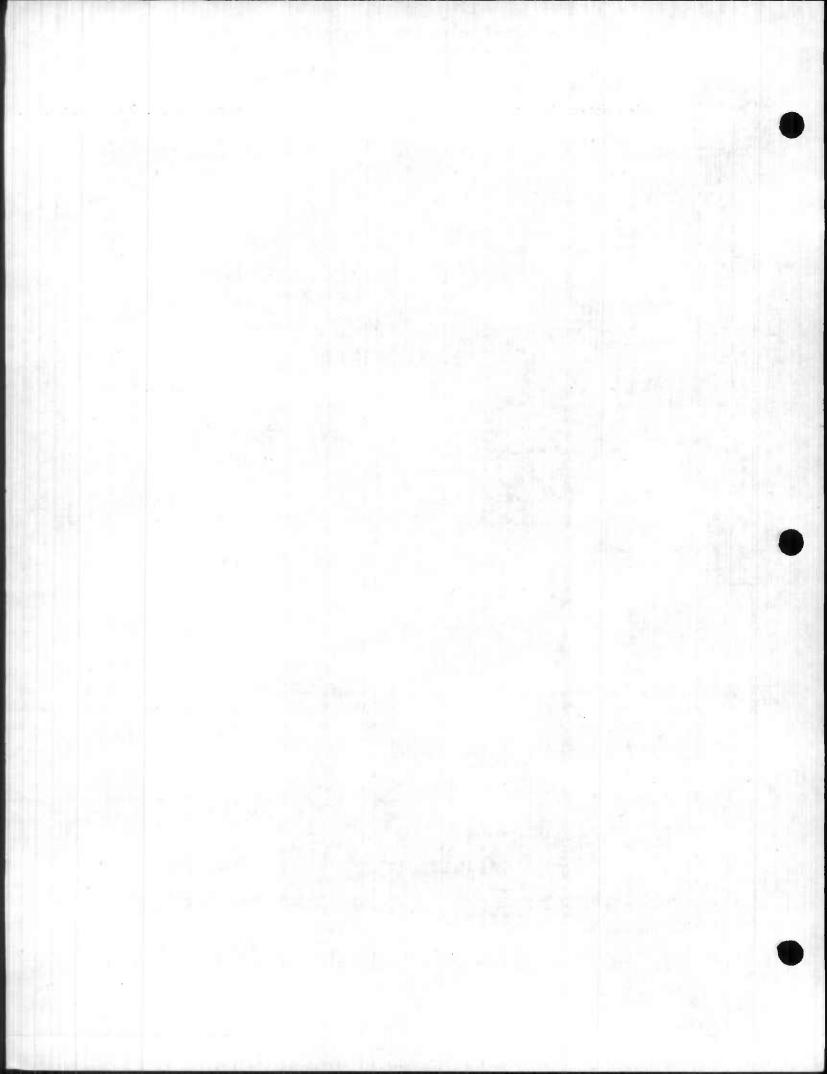
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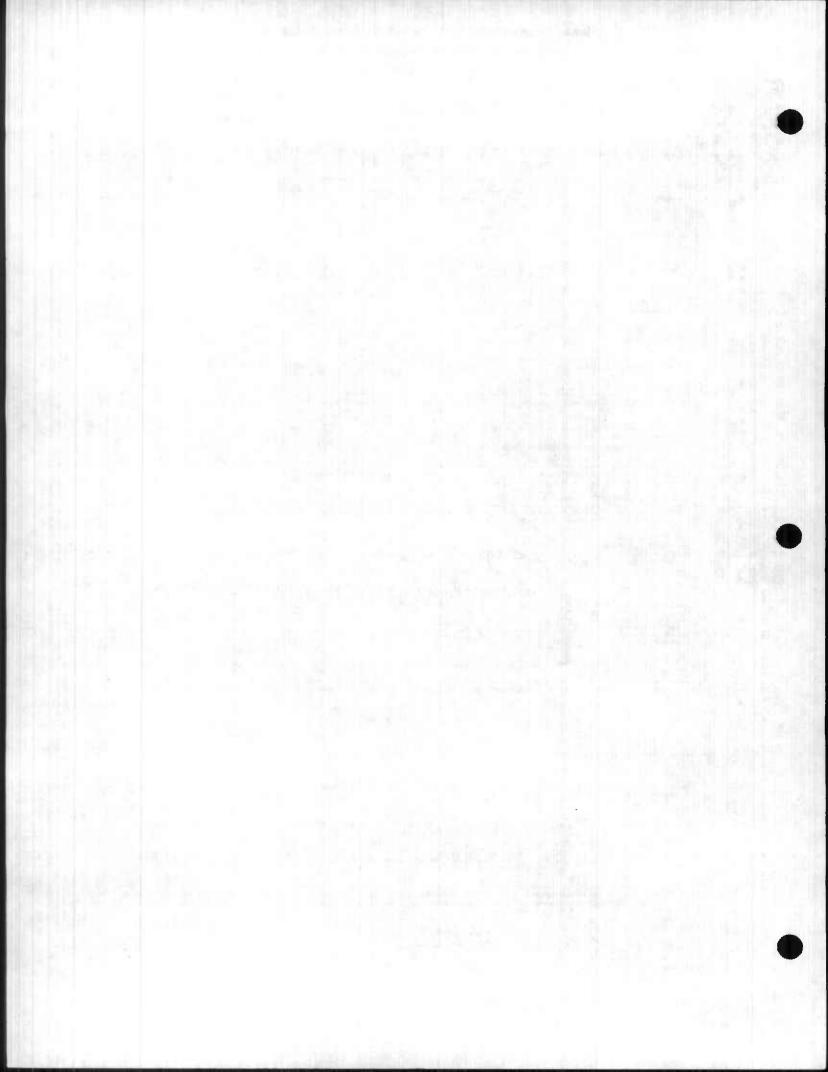
32. Registrar's Signeture



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State of Maryland / Department of Health and Mental Hygiene	426	59	L
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the fact	1 □ Nevar Merried 2 □ Merried	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, specify Cut		arto Rican, etc.)	Bled	ck, White,	etc.			
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	30. Nema and address of person who							/				
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Registrar	DEC 1 8	3 2000 Dener	1	14900	The same							

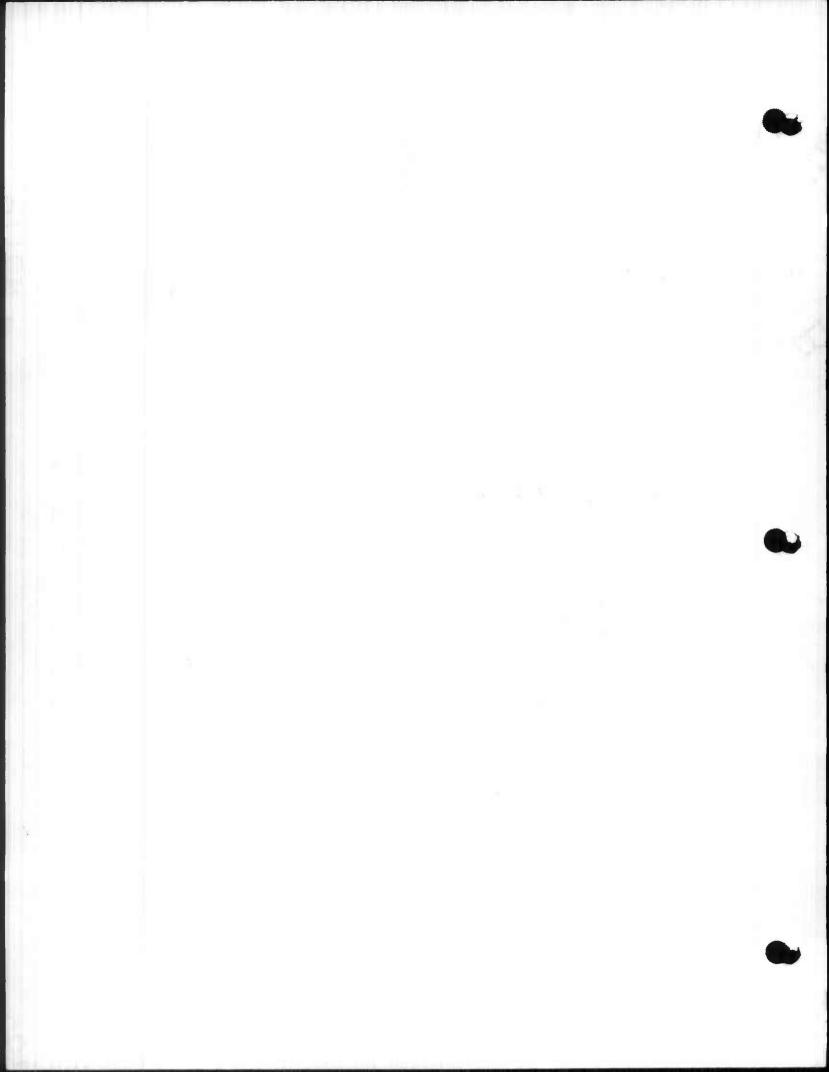


BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funera be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	CATE OF	DEATH	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
	Veronica	Eliza	beth N	Nunemaker Dec			ecember 20, 2000 3:			
			E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			3:30 pm M		
	213-50-4052	□ M 2 🔀 F	87 yrs.	MONTHS DAYS	HOURS MIN.	Dec 16, 19	1 3 Mo	ntry)		
	9n. FACILITY NAME (If not institution, give stree	f and number)		Oh CITY TOWN	OR LOCATION OF DE	Dec 10, 19		ryland		
Œ						ATH	9c. COUNTY OF			
5	College View Cente	r		Fre	derick		Fred	lerick		
DIRECTOR	10s. STATE 10b. COUNTY		10c. CIT	, TOWN OR LOCA	TION			10d, INSIDE CITY		
뜽	Maryland Frede	erick	A	damstow	1			LIMITS?		
7	10e. STREET AND NUMBER			Y. ZIP CODE			1 YES 2 NO			
R/	5703 Doubs Road		1.7	21710			A.			
FUNERAL										
	1 Never Married 2 Married	FORCES? 1 YE	S 2 XNO	If yes, s	pecify Cuban, Mexical		or No- 14, RAI	CE — American Indian, ck, White, etc.		
ВУ	3X Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 🗌 YE	S 2 KNO Specify	r	Spe	White		
	15. DECEDENT'S EDUCAT	ION	16a, DECEDENT'S	LIGHT OCCUPAT				***************************************		
COMPLETED	(Specify only highest grade cor	npleted)	(Give kind of w	ork done during m	ost of working	16b. KIND OF BUSI	NESS/INDUSTRY			
7	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Homema	_			wn Home			
₹ I	17. FATHER'S NAME (First, Middle, Last)									
	Patrick		O'Malle	37	Theres	ME (First, Middle, Maiden S	umame)	Molle 1 -		
BE								McHale		
9	19m. INFORMANT'S NAME (Type/Print)  Mrs. Patricia A. B	urrico/Fri	19b. MAJLING	ADDRESS (Street	and Number or Rural F	loute Number, City or Town,	State, Zip Code)	01710		
						amstown, Ma	ryland	21/10		
	20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION // DATE 28c. LOCATION City of Town State									
	St. Joseph's Cemtery Dec 23,2000 Buckeystown, MD									
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE/)			ND ADDRESS OF FAC		7			
	derot he	- Charles	Q- M00706	Kee	ney & Bas	sford Funer	al Home			
$\neg$	23. PART I. Enter the diseases, or con	polications that cause	ridu/uo	TUO E	ast Churc	en St, Fred	erick,	Maryland 217		
	shock, or heart failure. Lis	t only one ceuse on	each line.	ot enter the m	ode of dying, aucr	as cardiac or respire	ItDry arrest,	Approximata interval Between		
	IMMEDIATE CALISE /Final									
	disease or condition resulting in death)									
	DUE TO (OR AS A CONSEQUENCE OF):									
Z	Sequentially list conditions,									
CERTIFICATION	If any, leading to immediate									
2	Cause. Enter UNDERLYING CAUSE (Disease or injury									
쁜	that initiated events	DUE TO (OR AS	A CONSEQUENCE OF	):						
#	resulting in deeth) LAST									
	PART II. Other significant conditions of	ontributing to death	Above more annualists of the							
EDICAL			put not resulting in	i the underlyin	g ceuse given in i	Part I. 24a. WAS AN A PERFORM		b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
ă	Carcinona	07 600				1 YES 2 }	Xúe	COMPLETION OF CAUSE DF DEATH?		
Σ	Diabetes					′		1   YES 2   NO		
	DID TOBACCO USE CONTRIB	UTE TO CAUSE	OF DEATH YE	S I NO I	UNCERTAIN					
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT	H (Check only one)						
Š		OSPITAL:	rtpatient 3 DOA	OTHER:	ne 5 🗆 Residence	B Other (Specify)				
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF INJURY		OF 28c. IN.	IURY AT	28d. DESCRIBE HOW IN.	URY OCCURED			
BY	1 Netural 5 Pending	(Month, Day, Year,	) INJU		YES 2 NO					
	2 Accident investigation 3 Suicide 8 Could not be	28s. PLACE OF INJUI	RY At home, ferm, st	reet, factory, offic		28f. LOCATION (Street an	d Number or Rumi	Route Number		
COMPLETED	4 Homicide determined	building, etc. (Sp	pecify)	,		City or Town, State)	a realization by violet	TOUTO TOTAL ON		
W	29a. CERTIFIER									
<u>F</u>	(Check only CERTIFYING PHYSICIAL					to the cause(a) and mann				
Ö I	2 MEDICAL EXAMINER: C	on the basis of examinat	ion and/or investigation	, in my opinion, o	leath occured at the t	ime, data and place, and	due to the cause	e) and manner as stated.		
BE (	29b. SIGNATURE AND THILL OF CENTIFIER	His	- 11	. ^	29c. LICENSE NUM	BER	29d. DATE SIGNE	D (Month, Day, Year)		
	of west	nous	n /1/		018	186	Dre6	entel 20,200		
임	30. NAME AND ADDRESS OF PERSON WHO	OMPLETED CAUSE OF D	DEATH (ITEM 27) (Type,	Print)	~ ; 0	1				
	Steven Lev	enson	5151	Faire	wat,	Avieth A	1 has	1+ MM7,200		
	31. DATE FILED (Month_Day, Year)	32. REGISTRAR'S SIG	NATURE /	Goorks		1011	111000	1 111 2 20		
	DEC 2 2 2000	Seneva	9	done il						
			/-/	The ment						





Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 42696 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Yeer Nadine V. Oswinkle Dec 31 2000 8:42am 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death St Agnes Nursing & Rehabilitation Center Ellicott City Howard 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Yeer) March 23,1910 6. Sex Birthplece (State or Foreign Country) 1 □ M 2 1 F Months Deys Hours Yrs. 212 12 4135 Maryland Usuel Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 800 Winters Lane Apt 110 21228 United States 12. Was Decedent Ever In U,S. Armed Forces?

1 ☐ Yes 2X No If Yes, Give Yeer or Dates: 11. Maritel Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 □ Widowed 4 □ Divorced white 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Clerk Accounting 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Fred S. Snyder Jessie V. Johnson 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8347 I Montgomery Run Road Ellicott City, MD 21043 Nadine V. Brandt/Daughter 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 【XCremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 1-2-2001 Catonsville, MD ma044 22. Name and Address of Fecility
Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funeral Service Licensee WH 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Final Co hours disease or condition resulting in death) CORONARY GeNERALIZED ATHEROSCIEROSIS 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy RIPPLING 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of

**Physician** /Medical Examiner

signed by the e

peen

certificate

After this

b

page

Be

permit. Pages 1 and 2 should be filed. Department of Health and Mantal Hygic Important: If item 27 is marked other: any Injury or other traumatic event.

**Physician** 

/Medical

**Examiner** 

Director MD

Funeral

þ

Completed

**Funeral** 

Director

Hygiene. uther then "natural", or Itema 23s or 28s-f show rent, the Medical Examiner must be notified at

with the Maryland

altimore, Maryland 21215-0020

P.O. Box 68760.

Records.

Division of Vital

Examiner siclan end bunal-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Physician/Medical thet initieted events resulting in deeth) Lest the

1 Nature

2 Accident

3 ☐ Sulcide

29e. Certifier

4 Homicide

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

To the Hospital or Attending Phwithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

29b. Signeture end title of certifier

5 Pending Investigation

6 Could not be

ATTENSING AD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number D16200

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

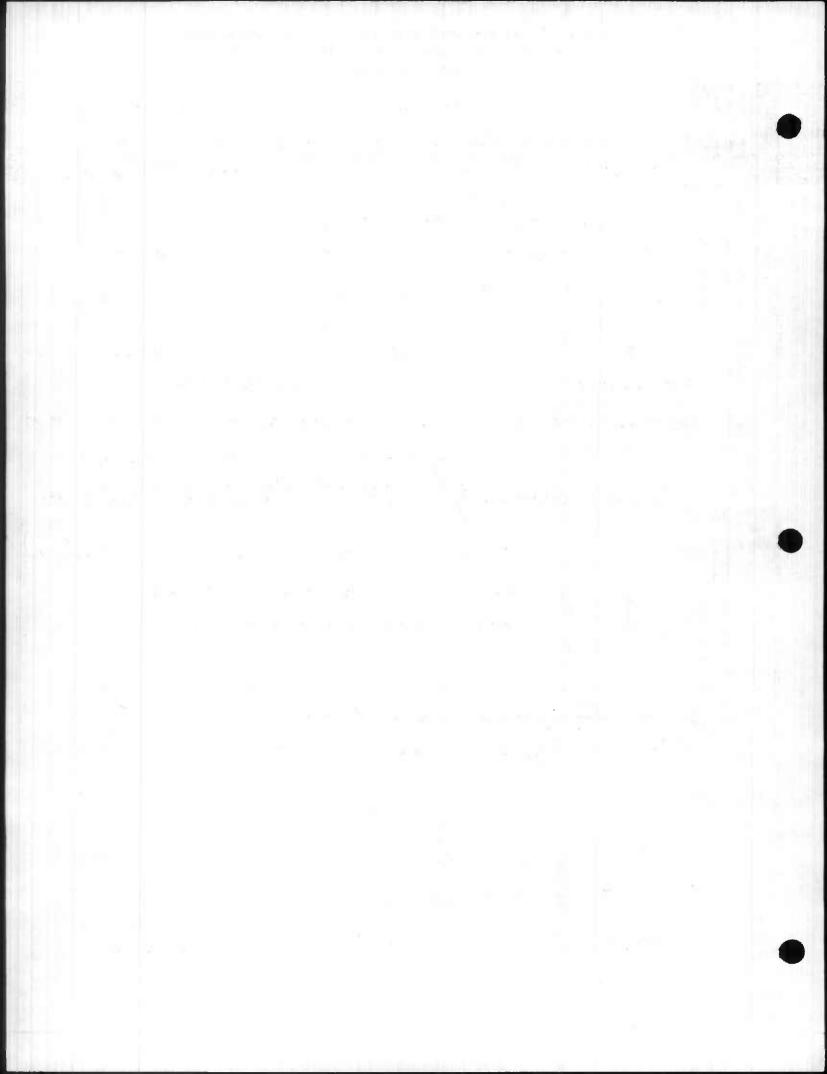
Jan 2, 2001

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

730-C MAIDEN CHOICE LA. CATONSVILLE, MD. 21228 NORBERTO M. MACHIRAN, M.D. 31. Date filed (Month, Dey, Year)

State Registrar

32. Registrar's Signeture JAN 0 3 2001



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 1753 Mary Margaret Ondus ELEMBER 2000 /Medical 4a Facility Name (ff not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (fn yrs. last birthday) If Under 1 Year Birthplaca (State or Foreign Country) **Funeral** 1□M XXF Months Days 185-38-6705 51 Director 20, 1949 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No Director W. Va. Berkely Falling Waters Nerns 23s or 28s-1 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 46 Eldred Lane 25419 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11 Marital Status Bleck, White, etc. 1 Never Merried 2KMarried 'natural', or 1 ☐ Yes 2 ☑ No Specify: Specify: by White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Charge Nurse Health Care 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nant of Health and Mental h and Mental i Edward Sherrow Kathrine Tometsko 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Dan Ondus / Husband Department of Health mportant: If flers 27 46 Eldred Lane Falling Waters, WVa 25419 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Dete 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 ☐ Other (Specify) Howard Univ. Coll. of Med 1/2/01 Washington, D.C. 21. Signature of Janeral Service License 22. Name and Address of Facility Lincoln & Lincoln Funeral Service 4315 Anacostia Ave., NE Washington, DC 20019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician Immediate Cause (Finel disease or condition resulting in death) /Medical neumoni Examine Examine physician and s the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 80 for use es ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t SNOWS, MARY MARGARET 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 s ils certificate h 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No Director: / 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide ofter Hospital or 24 hours of Funeral D letely filled I

State

edical

29a. Certifier (Check only one)

29b. Signature and title of gar

30. Name and dofress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

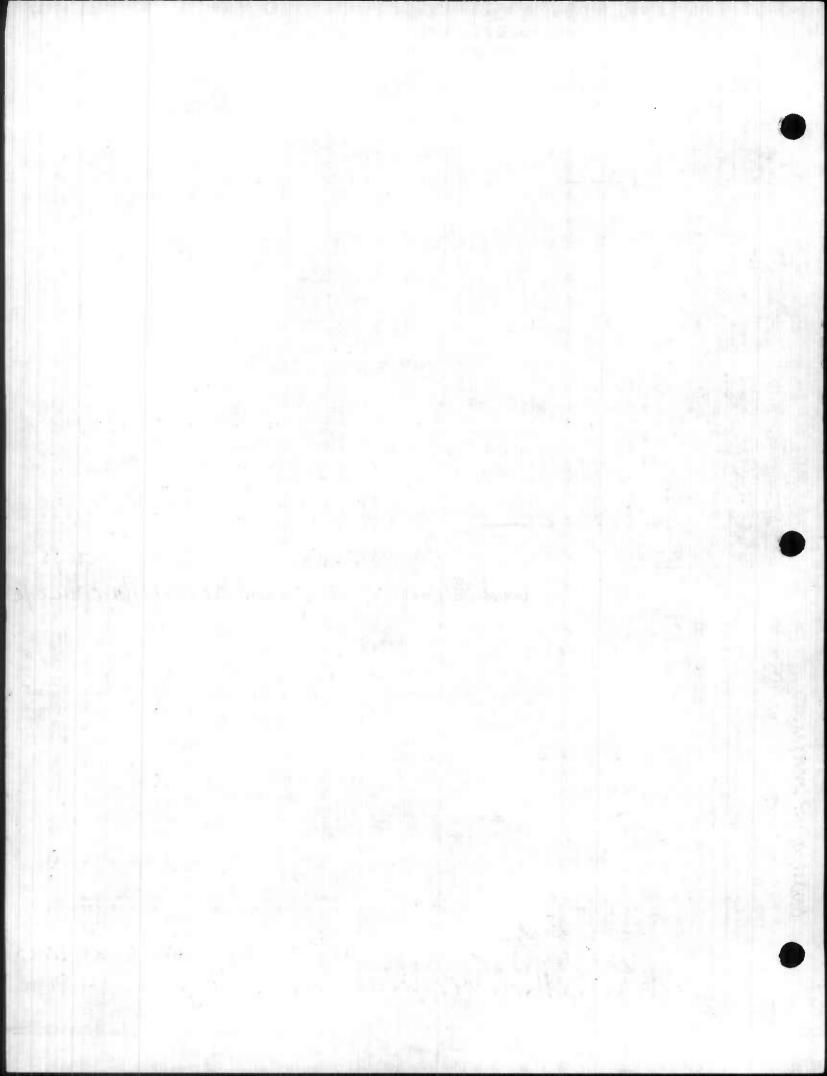
within 2

Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dey, Year)



Amended Item #19b, Per F.D., 12/20/2000, Carroll County, cew Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** December 18, 2000 Peggy Burdick Purcell 11:15pm /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Copper Ridge Sykesville Carroll County 7. Age (In yrs. lest birthday) If Under 1 Year 5. Sociei Security Number If Under 24 Hrs. Hours Min. Birthplace (Stete or Foraign Country) **Funeral** Days 1 □ M 2 🗓 F 75 Yrs. Director 003-14-6375 Sept 11, 1925 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1√2 Yes 2 □ No Director Carroll Sykesville 10e. Street and Number 10f. Zip Coda 10a. Citizen of Whet Country? 6 710 Obrecht Road 21784 U.S.A. Items 23e Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 11. Maritel Status Pages 1 end 2 should be filed within 72 hours effer or ent of Health end Mentel Hygiene. nt: If Item 27 is marked other than "naturel", or Iter 1 Nevar Married 2 Married 1 ☐ Yes 2€ No If Yes, Giva Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: specify:White þ 3 XWidowed 4 ☐ Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Antique Store Owner Antiques 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Surneme) Be William Burdick Sharrott Margaret 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health er fmportant: If item 27 is any Injury or other trauonce. Mr. Frank W. Grube, Jr. (Executor) 2109 LeRoy Drive Woosbine, MD 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other pieca) 20c. Location - City or Town, Steta 1 ☐ Buriai 2 ACremation 3 ☐ Removel from State All County Cremation Srv. 12/19/00 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee 22. Name and Address of Fecility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Sykesville, MD 21784 (410)-795-1400 Interval Between Onset end Deeth **Physician** Alzheiman Demontin Immediete Ceuse (Final diseese or condition resulting In deeth) /Medical Y11. Examiner Due to (or es e consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Undarlying Cause (Diseese or injury that initieted events resulting in daeth) Last Due to (or es e consequence of): Box 68760. Physician/Medical the Due to (or es a consequence of): esn signed by the a Pert II. Other algnificant conditions contributing to death but not resulting in the underlying causa givan in Part I. Division of Vital Records, P.O. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ρ 24b. Were autopsy findings aveilable prior to completion of cause of deeth? Completed 24e. Wes en autopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yas 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Manner of Death 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: 3 Suicida 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to tha ceuse(s) end mennar statad. edical 29a. Certifier within 24 ho To the Fune completely fi (Check only one) 29b. Signature end title of cartifier

29d. Date signed (Month, Dey, Year)

Confer O. Roisford ML 21186

State Registrar

**DHMH 16 Rav 6/95** 

) facto J. Man, Mo

Robert L. Moss

DEC 2 0 2000

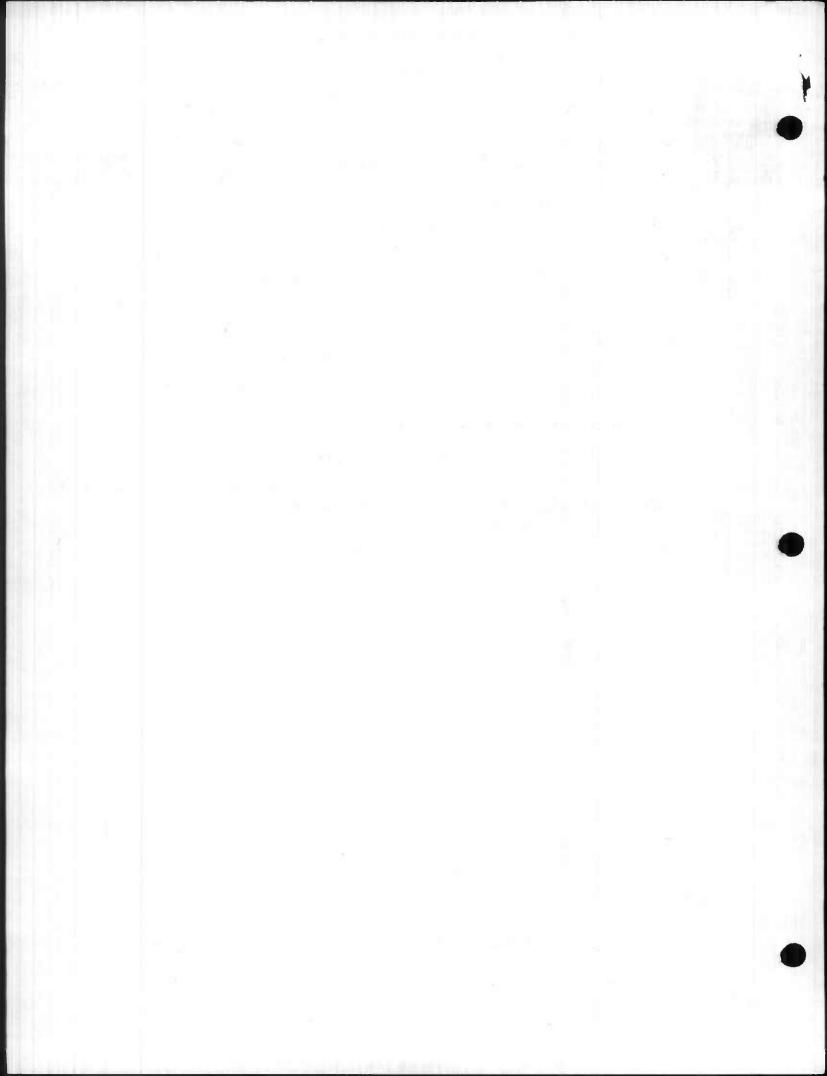
31. Dete filed (Month, Day, Yeer)

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

114

32. Registrer's Signeture

Businer



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			Ce	ertificate c	of Death	Re	eg. No.	
	1. Decedent's Neme (First, Middle, Last)	)	NO WORK			2. Dete of Deet	h	3. Time of Death
Physician	Otha Poval Palmor	Sr.				December	Day 2	Vear 08:38
/Medica Examine	An English Name (Mant londingles when				4b. City, Town, or L		4c. County	
LAMINITE	Washington County	Hospital			Hagersto	own	Washi	ngton
	5. Social Security Number 6. Sec		n yrs. last birthday	) If Under 1 Ye				9. Birthplace (State or Foreig
Funeral Director		M 2□F	67 Yrs.	Months Da	ys Hours Min.	8. Date of Birth (Month, Day, Sept. 12		lest Virginia
pu *	10a. State 10b. County	10	c. City, Town or I	ocation				10d. fnside City Limi
aho aho	Maryland Washingto		Hagersto					1  Yes 2 N
Ne N	all y land washing to	/11	nager 5 TO				0- 011	Day Carray O
urs after death with the Manyland of, or items 23s or 28s-f show Examines must be notified at	10e. Street and Number 118 Broadway			10f. Zip Cod	740		het Country?	
eep #5	11. Maritel Stetus	12. Was Decedent Ever Armed Forces?	r in U,S. 13	. Was Decedent	of Hispanic Origin? (Sp Juban, Mexicen, Puerto	pecify Yes or No-		- Americen Indian, c, White, etc.
8 6 8	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1□ Yes 2⊠ I			Specify:	White
be filed within 72 hours tal Hygiena.  d other than "naturel", avent, the dical Exp.	15. Decedent's Edu (Specify only highest grade	cetion e completed)	16a. Dec	edent's Usual Oc re kind of work do	cupation one during most of work tired)	of working		
within then	Elementary/Secondary (0-12)	College (1-4or 5+)		vate Ins			Music	
filed wil Hygien other thu	17. Father's Name (First, Middle, Last)			vale ins		ne (First, Middle, I		
d 2 should be flied within the and Mental Hygiena. T le marked other than treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event, the treumatic event	Royal Mailon Palm	ner				enee Trig		
should nd Men marke umartic	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mai	ling Address (Str	eet and Number or Ru	ral Route Number	City or Town,	State, Zip Code)
	Juanita M. Palmer	(Wife)			Hagerstown			
Hear Hear other	20e. Method of Disposition	2	20b. Place of Disp	position (Name of	-(2.42)	Date	20c. Location ·	City or Town, State
Pages ment of ant: If it	1 ⊠ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)			ematory or other		2-27-00	William	sport, Maryla
permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other pans.	21. Signature of Funeral Service License	21_		0sborne	Funeral Ho	ome 425	South C	Conococheague
	23s. Party Enter the disease, or complished, or heart failure. List only or	ications that caused the						Approximete
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frar of Mrecin by	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc. (S	- At home, farm, s Specify)	street, fectory, off	ice	28f. Location (Si City or Town	treet end Numb n, Stete)	er or Rural Route Number,
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To the Hospital or At within 24 hours after of to the Funeral Direct completely filled in by	29b. Signature end title of certifier						12/2/	
To the Hor within 24 h To the Fur completely	29b. Signature end title of certifier  30. Name and address of person who co			D C	055926		12/26	

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12700

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PLUMMER  Physician		Thomas Edwin			Journ	2. Dete of Death Month DECEMBER	Dey	Year	Time of Death : 30P.M.
/Medical Examiner	An Capilla Nama //fact institution sing				4b. City, Town, or Lo	ocation of Death	4c. County	of Death	
Funeral Director	Social Security Number     6. Security Number		last birthday) If Unc Yrs. Month	der 1 Yeer is Days	If Under 24 Hrs. Hours Min.	8. Dete of Sirth (Month, Day, July 12,	Year)	9. Birthplace Country)	(State or Foreig yland
Maryland H show fied at	10a. State 10b. County  Maryland Montgome	-	y, Town or Location						nside City Limits
h with the Ma 3a or 28a-f a at be notified				Zip Code	20850	10		Whet Country?	2
036 urs after death v alf, or thems 23s Examiner mast		12. Was Decedent Ever In U, Armed Forcas? 1 ⊠ Yes 2 ☐ No If Yes, Give Year or Detes: ₩.₩.	1□ Yes	cedent of H pecify Cubi	lispanic Origin? (Sp an, Mexicen, Puarto Specify:	ecify Yes or No- Rican, etc.)	14. Rad	ce - American I ck, Whita, atc.	ndian,
Maryland 21215-0036 a should be find within 72 hours at th and Mental hygiene. The marked other than "natural, or traumetic event, the Medical Examp To Re Completed by		cation	16a. Decedent's Us (Give kind of s lifa. DO NOT	work done use retire	during most of work	ing 1		usiness/Indust	
land 2			Owner	/Oper	18. Mother's Name	e (First, Middle, M	aiden Sumar	a Shop	
	Thomas E. Plummer  19e. Informent's Neme/Relationship (Ty  Ronald D. Price/	Nephew		nnell	Winitred and Number or Rur	erwood,	City or Town		355
Battimore, permit. Pages 1 at Department of Hea Important; if Nam; any Injury or other golde.	1 \( \text{Suriei} \) 2 \( \text{Cremetion} \) 3 \( \text{F} \) 4 \( \text{Donetion} \) 5 \( \text{Other} \) (Specify)  21. Signature of Funeral Service Licens  \( \text{Licens} \)  23a. Pert1. Enter the disease, or compleshock, or heart failure. List only or	ee  Jolemonth  Lations that caused the deet de cause on each line.	Olin 26401 h. Do not enter the m	ethod end Addre L. Mc Ridg node of dyin	ist Cem. 1 ss of Fecility lesworth e Road, I	P. A. Fu Damascus, or respiratory erre	neral Maryl	Home and 200	372 proximate orval Between sat end Death
/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth)	a. Itypertens	or as e consequence of	the	osclero	hz la	rdible	13 Eus	ie
60, be executed iclen and burial-transit	Ceuse (Diseese or injury	Dua to (c	or es e c <i>on</i> sequence d	of):					
Box 687 eath certificate attending physic	that initiated events resulting in death) Last	Due to (o	r es e consequence o	of):					
ords, P.O. Borequies that the death ean signed by the atterhould be detached for used by Physician	Pert II. Other aignificant conditions con	ntributing to death but not res	ulting in the underfyin	g ceuse gi	ven in Pert f.		s 2 No	ontributa to the	cause of death y 4回Unknow
e law						24a. Was ar parlorm	ed?	of dea	autopsy tindings ble prior to etion of ceuse th?
Vital I	25. Was cese referred to medical				26. Place of Deel	th (Check only one	9)		
Of Vita Physician: this certific ral director.	examiner?	Hospitel: 1 Inpatient 2	ER/Outpatient 3	DOA Oti	ner: 4 Nursing Ho	ome 5 Reside	nce 6 Dot	nar (Specify)S	CENE
Affer fune	27. Manner of Death  1 Neturel 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of injury M			28d. Describe ho	w injury occu	rred	
DIVISION Attentions after deat even Director: filled in by the	4 Homicide datarmined	28a. Place of Injury - At he building, etc. (Specif	oma, tarm, street, fact y)	tory, office		28f. Location (Str City or Town	eet and Num , State)	Der or Murai Ho	oute wumber,
Hospital 24 hours 5 Funeral letely filled	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledga, deeth occurred at the time, date end place, end due to the cause(s) end manner as: 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner as:								

30. Name and address of parson who completed ceuse of death (Itam 23a) (Type, Print)

31. Dete filed (Month, Day, Year)

29b. Signature end titla of certifian

32. Registrar's Signeture

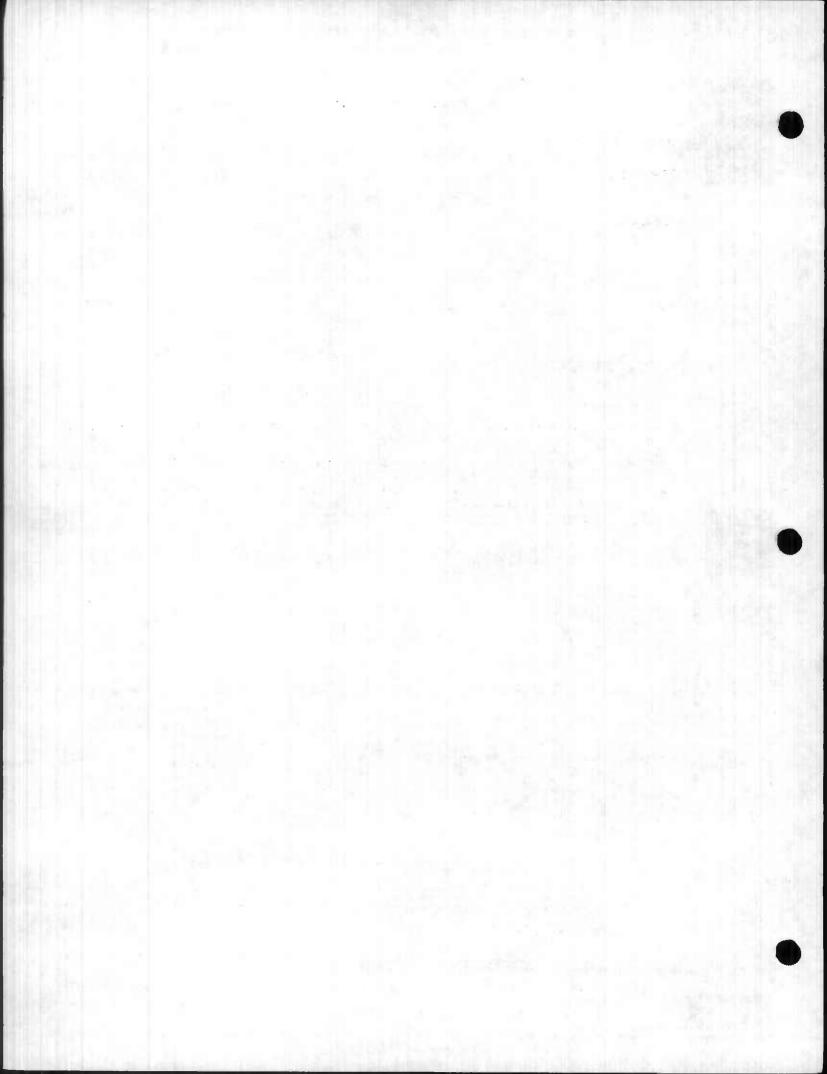
111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

DECEMBER 16,2000

State Registrar

29c. License number O.C.M.E.

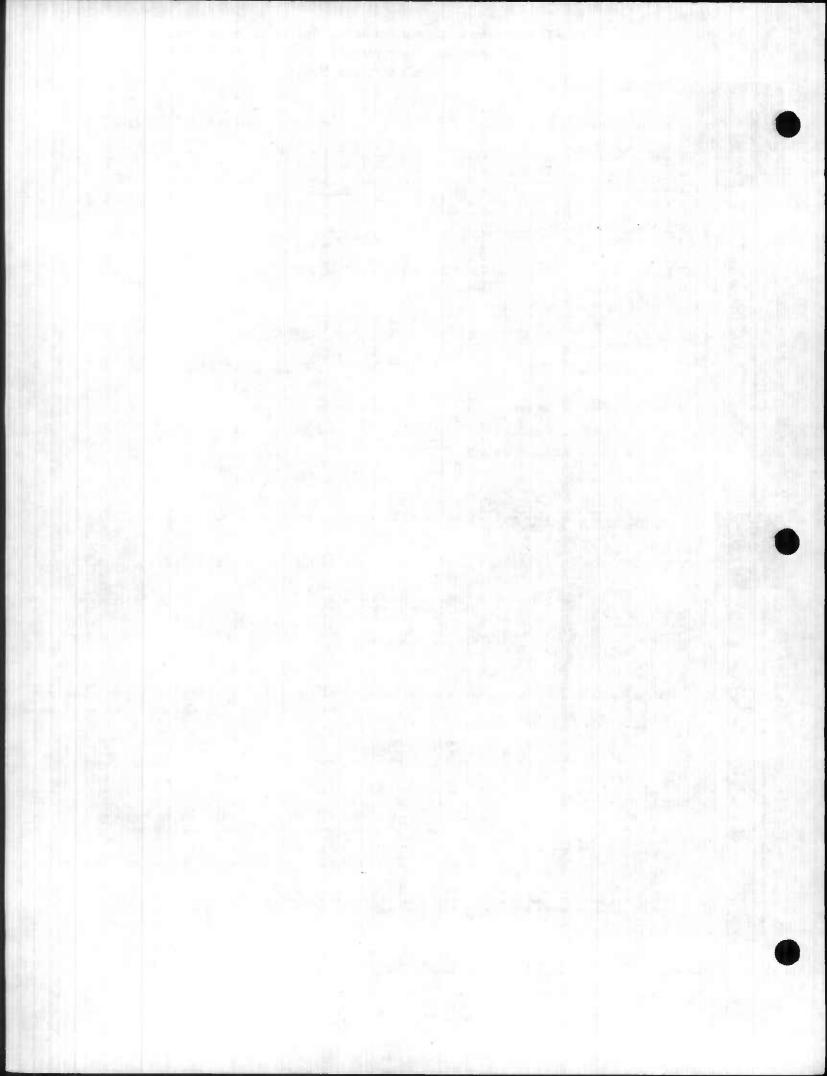


### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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1	6	-1	U	6

				Certificate	e of Death		Reg. No.			
		1. Decedent'a Name (First, Middle, L	est)			2. Dete of D			3. Time of E	eeth
	Physician	John Jaco	h Destman			Month	er 17. 2	Year 000	10:03	D M
	_/Medical	John Jaco 4a Fecility Name (If not institution, gi			4h City To	Decemb own, or Location of Dec		2 2 2	10:03	P.M.
•	Examiner									
		508 Grant Pl		last hirthdey) If Under		derick		ederi		_
	Funeral		Sex 7. Age (In yrs. 1 ☑ M 2 ☐ F	Months	Days Hours	Min. (Month, I	Day, Year)	9. Birthp	place (Stete or ntry)	Foreign
-	Director	213-24-8187	72	2 115.		May 29	, 1928	Mary	land	
	D .	Usual Residence of Decedent  10e. State 10b. County	100 Cit	Your or Location			-	1.	Od facida Cita	. I Jan Sta
	anyla ahov	10e. State 10b. County	Toc. Cit	y, Town or Location					10d. fnside City	
	r 28a-f show notified at	Maryland Freder	ick F1	rederick					1X Yes	∠ LI NO
	with the Maryland a or 28a-f show Libe notified at	10e. Street and Number		10f. Zip	Code		10g. Citizen of	Whet Cour	ntry?	
	th wit	508 Grant Place		2	1702		United	State	es	
	r thems 234	11, Marital Status	12. Was Decedent Ever in U	,S. 13. Was Deced	ent of Hispanic Or	rigin? (Specify Yes or I	No- 14. Rec	e - Americ	en Indien,	
	Her Pur	1 Never Merried 2 Married	Armed Forces? 1 X Yes 2 □ No	If Yes, speci	ify Cuben, Mexica	n, Puerto Rican, etc.)	Ble	ck, White,	etc.	
21215-0020	filed within 72 hours after thygiena. the tran *natural*, or the tran *natural*, or the transfer Earth or the	3 ☐ Widowed 4 ☑ Divorced	1 X Yes 2 No If Yes, Give Year or Detes: 48 -88	1 ☐ Yes 2	No Specify		Specify	v: whi	te	
Ö	hou hou	15. Decedent's E	1	16e. Decedent's Usua	Occupation		16b. Kind of B	usiness/in	dustry	
5	led within 72 ho ygiena. ••• than *natura nt, fre Wedled	(Specify only highest gi		(Give kind of word	k done during mos	st of working	100.11.11.001.0	201110033111	ouddiny.	
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7	il Hygiena. other that vent, men.	47 Fathada Nama (First Afiddle Las	4	telephone		SOT er's Name (First, Midd			rernmen	С
Ē	0 = 0 5	17. Father's Name (First, Middle, Las	0				e, Maloeri Surrian	10)		
<u>\$</u>		Glenn Lee Putman			Pea	rl Harn	e			
Maryland	end end end	19a. Informent's Neme/Relationship	(Type, Print)	19b. Meiling Address	(Street end Numb	per or Rural Route Nun	nber, City or Town,	Stete, Zip	Code)	
	C # 64 F	Debra Johnstin /	daughter	14 N. Char	lotte St	Manheim	. PA 17	545		
9		20e. Method of Disposition	20b. F	Plece of Disposition (Nem- cemetery, cremetory or of	ne of	Dete	20c. Location		own, State	
altimore,	ages ont of t: If h	1 Buriel 2 Cremation 3	_Hemoval from State	sthaven Mem.		12/22/0	0 Frede	m i ale	MD	
圭	rtan njun	4 Donetion 5 Other (Spec								
Ba	permit. Pages Department of Important: If It eny Injury or once.	21. Signature of Funeral Service Lice	1 1/1 /	22. Name end	Address of Fech	<sup>ity</sup> Stauffer	Funeral	Homes	, P.A.	
_	00200	garqueun	2 Run	1621	Opossumt	own Pike,	Frederic	k, MI	2170	2
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications thet caused the deat	h. Do not enter the mode	of dying, such es	s cardiac or respiratory	errest,		Approximete Interval Betw	000
	Physician	Shock, of heart failure. List offi	one cease on each mie.					1	Onset end De	
	/Medical	Immediate Cause (Final	· metaita	T. A AA	Comon	Achain	AZIMA	1	3 m	11
	Examiner	disease or condition resulting in deeth)			centre	arell	avyace	- 1	O NVC	00
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68760,	the the	that Initiated events resulting In death) Lest	Due to (o	r as a consequence of):						
9 ×	ling p									
0	ettending for use ex	THE REPORT OF THE PARTY.	G,							
B.	the death c y the ettenc ached for us hysician.	Part il. Other eignificant conditions	contributing to death but not res	ulting in the underlying ca	ause given in Part	I. 23b. D	d tobacco use co	ntribute t	o the cause of	death?
0	The law requires that the death coate has been signed by the ettence, page 2 should be detached for us.	1 - 1 - 1 - 1 - 1 - 1	· ml TA · D	1 - 2/2/211		1	Yes 200 No	3□ Pro	bebly 4 U	Inknown
9	signed be del	Carcanana	C 07 1110 181	ander						
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Ö	been si should should	allacoles 11	10/4/14				rlormed?	av	raileble prior to empletion of ca	
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H	The is pege	COYMANYO	12/04/ 4C	LEXCURR		10	Yes 2 No	1 1	☐Yes 2☐ N	40
Vital	certificata rector, per	25. Was case referred to medical			26. Plac	e of Deeth (Check on)	y one)			
>	2 00	exeminer?	Hospital: 1   Inpatient 2	ER/Outpetient 3 DO	A Other: 4 N	lursing Home 5 Re	esidence 6 Ott	ner (Speci	ty)	
of	Physical ser	27. Mannel of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of	8c. Injury et Work?	28d. Describ	e how injury occur	rred		
0	th. After funer	1 Waturel 5 Pending Investigation		Injury M	1 Yes 2	] No				
Division	tal or Attending P rs efter death. el Director: After ti led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not		ome, farm, street, fectory	, office	28f. Location	(Street and Num	ber or Run	el Route Numb	oer.
Š	or John in Directif	4 Homicide	building, etc. (Specif	(y)		City or	own, State)			
	Ille of Ille	200 Contiller 457/2-NA in 2							and a sure	
	n 24 hospi n 24 hound he Funer pletely fill edical	(Check only 2 Medical Exa	hysician: To the best of my kno miner: On the basis of exemina							
	To the Hospital or Attending Within 24 hours effer death To the Funeral Director: completely filled in by the Medical Certifical	one)	and menner steted.		42		201 7	1 00 0	Day M.	
	Vit Con	29b. Signature and title of certifier	11 / 20	29c	. License number	^	29d. Dete signe	Month,	Day, Year)	
		11/1/1/10011	190 101/11	001	0203	5,2	121	181	00	
		30. Name and eddress of person who	completed ceuse of death (Item	n 23a) (Type, Print)			7	-		
		Dr. William Co			doriol	MD 21702				
	State	31. Dete filed (Month, Day, Year)	32. Registrar's Signe	Drive, Fre	derick,	MD 21702				
	State	DFC 1	8 2000 \$ 2000	me la	1					

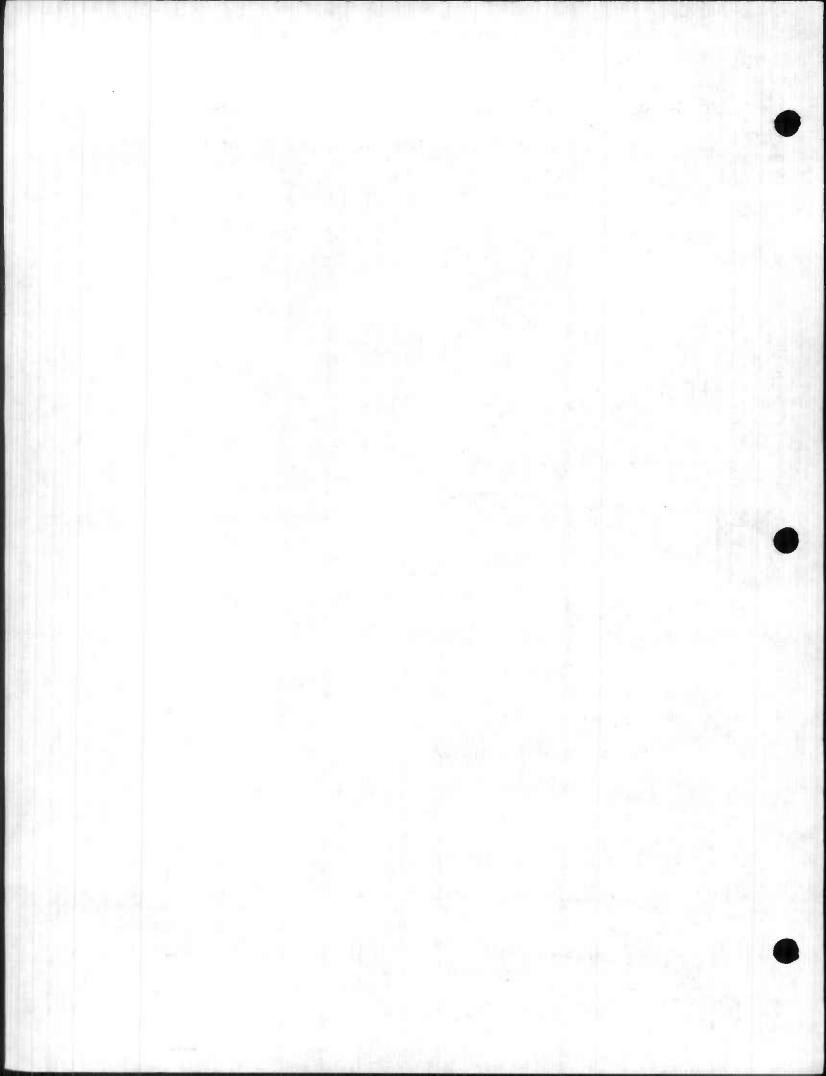


# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 42703

			C	ertificate o	f Death		Reg. No.		
tainn	1. Decedent's Name (First, Middle,	Last)				2. Date of D Month	eath Day	Year	3. Time of Death
nysician Medical	MARY	TARRAN				DE		2000	5:25 A.M.
aminer	4a Facility Name (If not institution,	give street and number)	e en le	1-31-1	4b. City, Town, or	Location of Dee			
	HOWARD Cour	174 achers	m_ Hos	PITBL	Cow	MBIA	How	MRI	
al			In yrs. lest birthda	(ay) If Under 1 Year	er If Under 24 Hrs	8. Date of Bi		9 Birtholi	ace (State or Foreign
	089-16-3461	10 M 20 F	83 Yrs	Months Day	rs Hours Min.	03-13-	ay, Year)	New Y	York
ч	Usual Residence of Decedent					100 10	1711	IICW 2	COLK
	10a. Stete 10b. County	1	Oc. City, Town or	Location				10	d. Inside City Limits
ō	MD Howard		Ellicot	City					1 ☐ Yes 2X No
Director	10e. Street and Number			10f. Zip Code	•		10g. Citizen of V	Vhat Count	in/?
	3004 North Rid	no Pond		2104			United S		
Funeral	11. Maritel Stetus	12. Wes Decedent Ev	er in IIS 1			Specify Vee or N		e - America	
5		Armed Forces?	61 H1 O, 5.	If Yes, specify Co	f Hispanic Orlgin? (S uban, Mexican, Puer	to Rican, etc.)	Blac	k, White, e	
2	1 Never Merried 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Yeer or Dates:		1□ Yes 2□XN	lo Specify:		Specify	. Whi	ite
			100 Do	d de Hei el O			10h Kind of B	uninnan And	· · · · · ·
Completed	15. Decedent's (Specify only highest		(G	cedent's Usual Occ ive kind of work dor a. DO NOT use reti	ne during most of wo	rking	16b. Kind of Bu	1211/622/11/01	ustry
dw	Elementary/Secondary (0-12)	College (1-4or 5+)	In						
	12	4		Homemal				home	
Be	17. Father's Name (First, Middle, La						e, Maiden Sumam	10)	
0	Joseph Thomas	Crowley			Mary Mary	Muldoon			
	19a. Informant's Name/Relationship	(Type, Print)			et and Number or R				
	Mario A. Parra	an/ Husband			idge Road.	Ellico	t City,	MD 21	1043
	20a. Method of Disposition		20b. Place of Discometery.	sposition (Name of crematory or other p	olace)	Date	20c. Location -	City or Tov	wn, State
	1 Burial 2 Cremation 3 4 Donation 5 Other (Spe			ivet Ceme		12-20-20	00 Fred	derick	k, MD
	21. Signature of Funeral Service Lie	**		22. Name and Add	1 15 10				
		1157					Funeral		
	Daymond	1 eler	2000	4.	ssumtown I			, MD 2	
	23a. Part 1. Forer the disease, or co shock or heart failure. List or	implications that caused the fly one cause on each line	ne deeth. Do not	enter the mode of o	lying, such as cardia	c or respiratory	errest,		Approximete Interval Between
								1	Onset and Deeth
	Immediate Ceuse (Final disease or condition	. CARE	SIRC	ARRIT	AIMHTY				
9	resulting in death)		ue to (or es e con					1	
ne		Hyor	RIGNS	ive Ite	per I	DISCAS		O.	em A-
Examiner	Sequentially list conditions		ue to (or es e con		,,,,,		= .	11/6	emde.
	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying							1	). 4-
	that initiated events		PERICA					K	cemose.
edical	resulting in death) Last	Di	ie to (or as a con:	sednauca oi);					
3		d							
Physician									
ysic	Part II. Other significant conditions	contributing to death but	not resulting in th	e underlying cause	given in Part I.	23b. Die	f tobacco use co	ntribute to	the cause of death?
F	PARMINSO	man.				1	Yes 20 No	3 Prob	ably 4 Unknown
2	12,500,000						,		
ted	Am, E	BRILLAN	001				s en autopsy lormed?	ava	ere eutopsy findings ailable prior to
pie	14.161125	SICILLIBII	011.						npletion of cause death?
Completed						10	Yes 2 No	1	Yes 2 No
	25. Was case referred to medical				06 81				
Be	examiner?	Hospital:	-5		Other:	ath (Check only			
. To	1 Yes 2 No	1 Dippatient		tient 3LI DOA	4 Li Nursing i		how injury occur		/)
Certification:	27. Manner of Death  12 Natural 5 Pending	28a. Date of Injury (Month, Day )	(ear) 28b. Tim-		njury at Vork?	Zod. Describe	TOW INJURY OCCUP	190	
cat	2 Accident investigat 3 Suicide 6 Could no	t he			☐ Yes 2 ☐ No				
Ē	3 Suicide 6 ☐ Could no determine		y - At home, farm, (Specify)	street, factory, office	Ce	28f. Location City or To	(Street and Numb own, State)	per or Rurai	I Houte Number,
i i									
	29a. Certifier	Physician: To the best of	my knowledge, de	eath occurred at the	time, dete end place	e, end due to the	e cause(s) and ma	anner as ste	eted.
edical	(Check only 2 Medical Ex	aminer: On the besis of e	xamination and/o	investigetion, in m	y opinion, death occ	urred at the time	, date end place,	end due to	ine cause(s)
M	29b. Signature and title of certifier			29c. Lice	ense number	P 10 301	29d. Date signe	d (Month, L	Day, Year)
	1 200	· 0 m	,	Da	2680		DEC	7 7	(Trans
		~ ''			2000		-	200	300
	30. Name and address of person with	0 -	tn (Item 23a) (Typ	oe, Print)	rown Pik		Euro	11/1) 3	1042
	SM34 SHEIKH	m.0 4051	DAUTI	nore Ivai	JONAL LIK	C #4E	LUIC	OTT (	LTY
tate	31. Date filed (Month, Day, Year)	32. Registrar	s Signeture	1					

DHMH 16 Rev 6/95

Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 42704 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Physician 800 hrs Hilda Russell Rulewich /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 350 Sunbrook
5. Social Security Number Lane Hagerstown
If Under 24 Hrs. 8, Dete of Washington If Under 1 Year 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foraign Country) **Funeral** Min. Days 1□M 20 F Months Hours Director 137-12-5122 27, 1922 New Jersey Usual Residence of Decedent with the Maryland 10a. Stafa 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or frems 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19229 Meadow View Drive death 21742 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces?

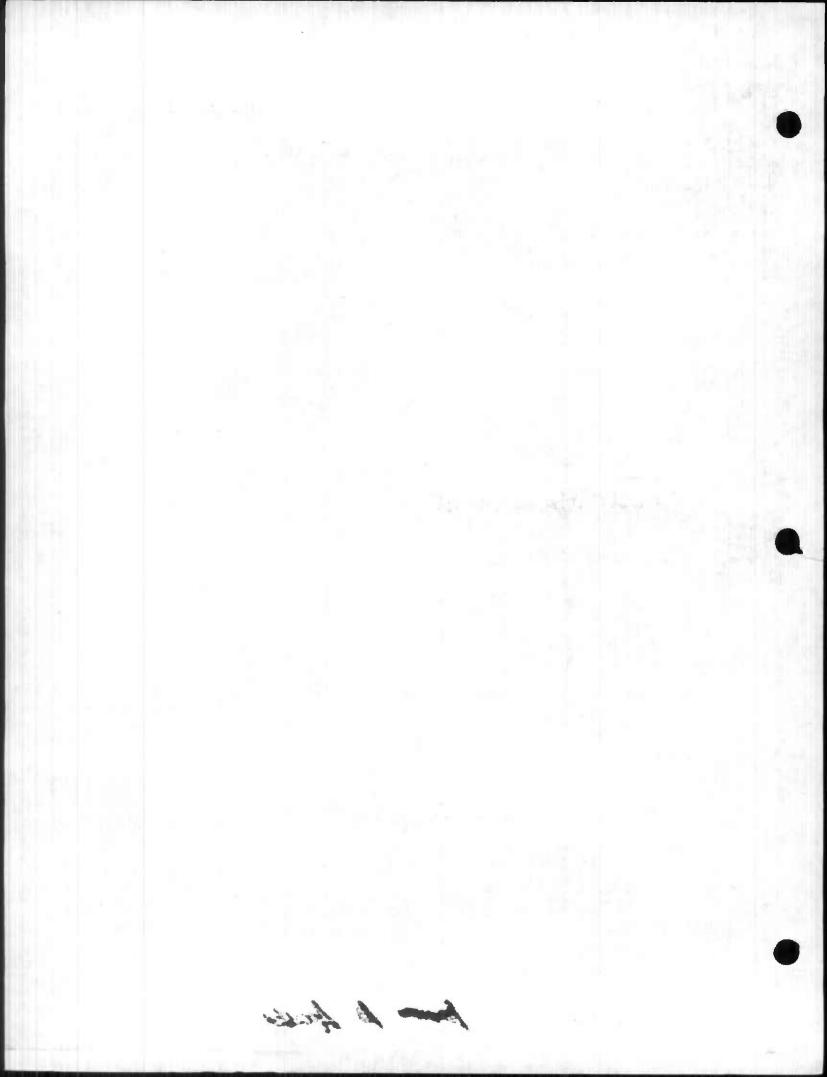
1 Yes, 2 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, Bleck, White, etc. permit. Pages 1 and 2 should be illed within 72 hours after of Department of Health and Mental hygiena. Important: if them 27 is marked other than "natural", or from any injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Automobile Club Elementery/Secondary (0-12) College (1-4or 5+) travel advisor of Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) George Henry Russell Hilda Rausch 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Joseph R. Rulewich, Sr. Husband 19229 Meadow View Drive Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 □ Dunation 5 □ Other (Specify) Rest Haven Cemetery 12/23/00 Hagerstown, Maryland 21. Signature of Funeral Service License Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 8years Examiner Encephalopathy from Padiation and Chemothappy Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Box 68760, Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of). P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? page 2 s 1 Yes 1 Tyes 2 No certificata of Vital 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Daughter 5 1 Yes 2 No Other: 4 Nursing Home 5 Residence edical Certification: To 1 Inpetient 2 ER/Outpatient 3 DOA this **Funeral** 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division To the Hospital or Attanding 1 Netural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 6 Could not be determined 28l. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end manner es stated.
2 Hedical Examiner On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 22 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Campus Drive, Suite 130 Hagerstown, MD. 2 Sepre Newman 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 6 2000 Registrar

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## Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended item#18 12/18/2000 FCHD.KS Amended#6 Reg. No. 2. Dete of Death Month 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month Dec. 14, 2000 **Physician** 9 A.M. Eileen Horwath Rose /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Frederick Middletown 6707 Christmasberry Ct. 7. Age (In yrs. last birthday) If Under 1 Yeer | If Under 24 Hrs. | 8, Dete of Birth (Month, Day, Year) 1946 9. Birthplace (State or Foreign Country) Wisconsin 5. Social Security Number **Funeral** Deys Months Hours 398-40-2101 Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at 1 Yes 2 No MD. Frederick Middletown Director 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 21769 U.S.A. 6707 Christmasberry Ct. Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indian, Black White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 5 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) medical nurse is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Merital Hy Important: If them 27 is manked oth any injury or other traumatic even Be Dorothy Mullins Elmer Horwath Dorothy Mullen 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 6707 Christmasberry Ct., Middletown, MD. 21769 Charles Rose (Husband) 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 🖾 Removal from State 12/18 Ashtabula, Ohio St. Joseph's Cemetery 4 ☐ Donation, 5 ☐ Other (Specify) of of Funeral Service Lice 22 Name and Address of Facility
Donald B. Thompson Funeral Home 21769 31 E. Main St., Middletown, MD. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): . attending p signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? should Completed 24a. Wes en eutopsy pege 2 s 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No certificata late or Attending Physician: Ts after death.

I Director: After this carifical ed in by the funeral director, p Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 (Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or A within 24 hours after To the Funerel Direcompletely filled in b 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated. edical 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signeture and title of ced lies 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) 32. Regi

ESKander

Elhamy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

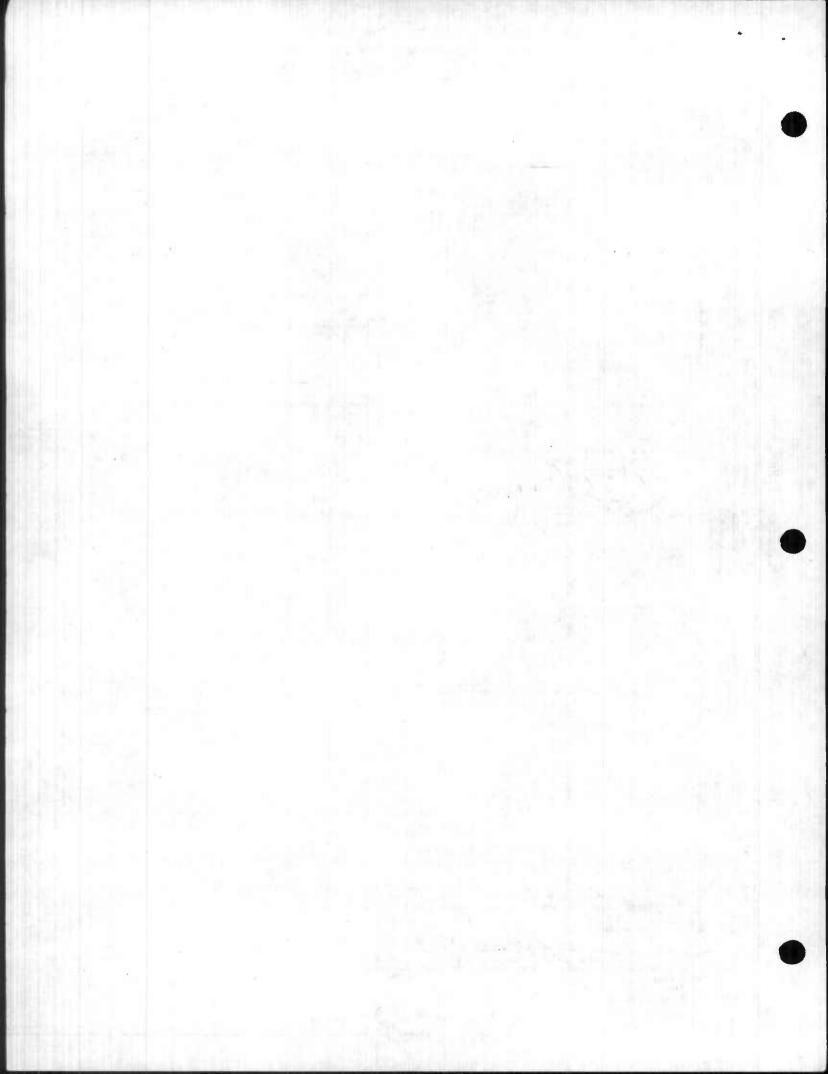
32. Registrer's Signeture

2000 Separa

MD

& Sports

street Frederick MD 2170

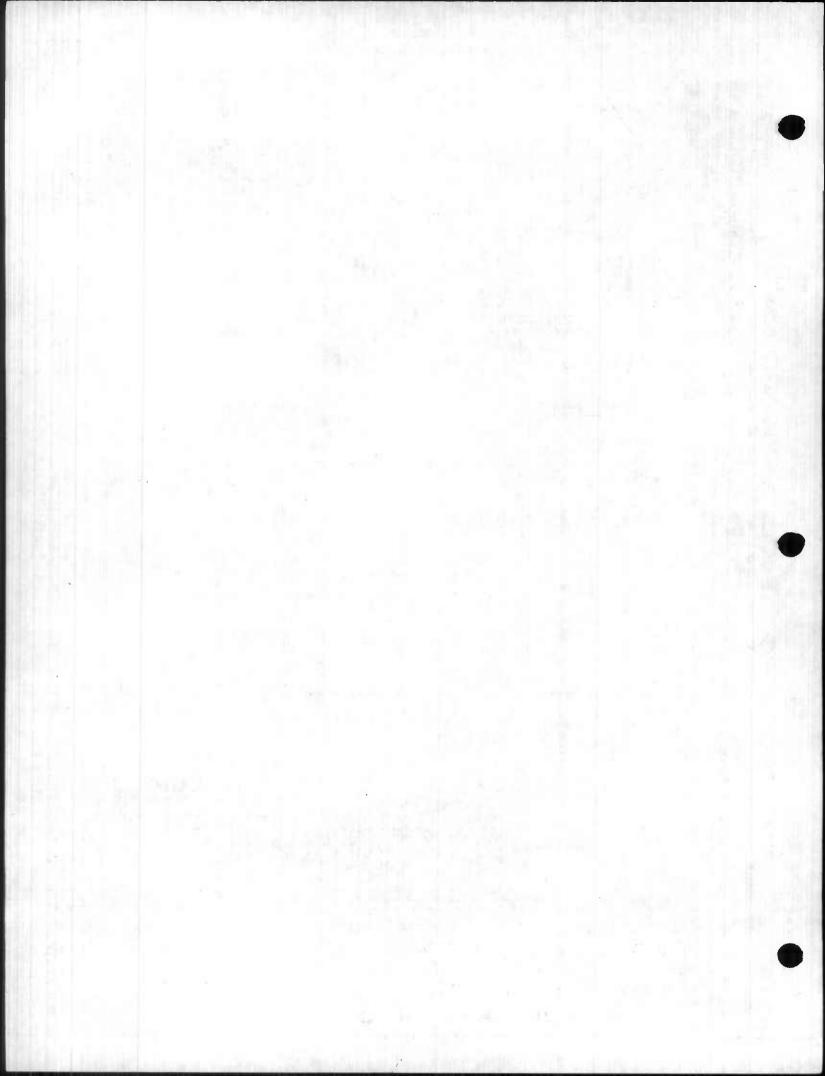


Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** Ridall Margare + 17 December 2:24 am 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 6. Sex 7. Aga (In yrs. last birthday) | H Undar 1 Year | Months | Days University of Baltimore If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) Birthplaca (Stata or Foreign Country) 5. Social Security Number **Funeral** 1□M 20F 175-28-7059 Director Pennsylvania Usual Rasidence of Decedent 10c. City, Town or Location 10a Stata 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas Z No MD Frederick Jefferson Director 10a. Street and Number 10f. Zip Coda 10g. Citizan of What Country? United States 21755 2391 Broad Run Court Funeral 14. Race - Amarican Indian, Black, Whita, etc. 12. Was Decedant Evar in U,S. Armad Forcas? Was Dacedent of Hispanic Origin? (Specify Yas or Note Yas, specify Cuban, Maxican, Puarto Rican, atc.) hours after 1 Yas 2 No If Yas, Give Year or Datas: 1 Navar Married 2 Married specify:White 1 ☐ Yas 2 No Specify: by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) N/A 12 Homemaker 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Mental Joseph Zdravecky marked Elizabeth Horvath To should 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stete, Zip Code) and 19a. tnformant's Name/Relationship (Type, Print) Pages 1 and 2 st ment of Health an tant: If Ilsem 27 is 1 ä Shari Ridall/ Daughter 2391 Broad Run Court, Jefferson, Maryland 21755 Baltimore, 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Other (Specify) Resthaven Memorial Gardens 12-19-2000 Frederick, MD 22. Nama and Addrass of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD, 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on sech line. Approximata tnterval Between Onset and Death Physician /Medical Immediate Cause (Final Sepsis weeks diseasa or condition rasulting in death) Examiner Due to (or as a consequanca of): Physician/Medical Examiner months multiple myeloma been signed by the attending physician and should be detached for use as the burial-transit certificata be executed Sequentially list conditions, if any, teeding to immadiata causa. Entar Undarlying Cause (Disaase or injury that initiated events rasulting in death) Last Dua to (or as a consequanca of): Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Division of Vital Records, p The law requires 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate al or Attending Physician: T s after death. I Director: After this certifical ed in by the funeral director, p Be 25. Was case refarred to medical 26. Piece of Deeth (Check only one) axaminar? Hospital: 1 Anpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 28e. Deta of Injury (Month, Day Year) 27. Menner of Deeth 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 Netural 1 Yas 2 No 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 6 Could not be detarmined 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) filled in by 4 Homicide Hospital C To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Cartifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier l Keis - Holt, MD P14648 D'ecember 17, 2000 30. Name and address of person who completed causa of daath (Itam 23a) (Type, Print) Battimore MD Greene ST Amber Reiss-HolT 22

State Registrar 31. Data filed (Month, Pay, Year)
UEC 1 9 2000

32 Bogistrar's Signatura



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 4 2 7 0 8

Certificate of Death

			Certifi	cate of	Death	Re	g. No.			
	1. Decedent's Nama (First, Middle, Last,			Merry		2. Data of Death		Year	3. Tima of Dear	ath
Physician	Flo Thelma	Smith				Decem/	Day 18	2 00 3	19:0	45
/Medical Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death	4c. County			
LAUTHITE	Washington Cou	nty Hospital			Hagerst	OWD	Was	shing	ton	
Funeral	5. Social Security Number 6. Sec			Under 1 Year	If Under 24 Hrs	8. Date of Birth	Years'	9. Birthpla	ca (Stete or For	reign
Director	217-10-2585	M XXF 8	32 Yrs. Mo	onths Days	Hours Min	8. Date of Birth (Month, Dey, Sept.8,1	918	Mar	yland	
	Usual Residence of Decedent									
M M	10a. State 10b. County	10c. City	y, Town or Locatio	n				10	d. fnslde City Lli	
or items 23e or 28e-f show entrer must be notified at / Funeral Director	Maryland Washir	gton	Shar	psburg					1   Yas 2 (2)	No
Director	10e. Street and Number		10	Of. Zip Code		10	g. Citizan of V	Vhat Counte	y?	
4 0	5729 Sharpsbur	a Pike			21782		1	JSA		
free must		12. Was Decedent Ever in U. Armed Forcas?	S. 13. Was			Specify Yes or No- to Rican, atc.)	14. Rac	e · America		
E S	1 ☐ Never Married 2 ☐ Married	1 ☐ Yas 2 ☑ No				to rican, atc.)			IC.	
0	3 ☑ Widowed 4 □ Divorced	If Yes, Give Yaar or Datas:	101	Yes 2 No	Specify:		Specify	. Wt	nite	
Completed	15. Decedent's Edu	cation	16a. Decedent's	s Usual Occup	ation during most of w	din	16b. Kind of Bu			
ple	(Specify only highast grad Etementary/Secondary (0-12)	College (1-4or 5+)		OT work dona VOT use retired		orking				
E	8	Oologo (1-401 54)		Housew	ife			Hor	ne	
Be C	17. Father's Neme (First, Middle, Last)					ma (First, Middle, M	faiden Sumem			
	Charles Edgar	Bender			Agne	s May S	tull			
To	19e. Informent's Name/Relationship (T)		19b. Meiling Ad	ddress (Street		lural Route Number		Stete, Zip (	Code)	
	Grafton V. Smith.	IrSon	5025 H	larper t	s Ferry	Rd. Sharp	sburg.	Mary	land 217	782
	20a. Method of Disposition	20b. F	Ptace of Disposition	n (Neme of		Date	20c. Location ·	City or Tov	vn, State	-
5	1X) Burial 2 Cremation 3 F	temoval from Stata	cemetery, cremetor			10 01 00	CL		Maria Fair	
eny mjury c	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		. View C	me and Addre		12-21-00	Snarpsi	ourg,	Marylar	na
D C		,	Osb	orne F	uneral H	ome, P.A.				
	Doy Elsi		425	S. Co	noçochea	gue St.Wi	Iliams	port,		5
	23a. Part1. Enter the disease, or compl shock, or heert feilure. List only or	ications that ceused the deat ne cause on each line.	h. Do not enter the	e mode of dyir	ng, such as cardi	ic or raspiratory arre	est,		Approximete Interval Between	
ian		A A							Onset and Deat	ın
cal	fmmediate Cause (Final disaase or condition	melastatie	lung	can	neer			1	mouls	
ner	rasulting in daath)		or as a consequence							
Examiner								1		
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dical Examir	Sequentielly list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseese or injury									
edicai	that initiated events resulting in death) Last	Due to (o	r as e consequand	ce of):						
×		4								
for use as			1 1 1 1 1 1 1					1		
be detached for use by Physician/	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the under	lying cause giv	ven in Pert I.	23b. Did to	bacco use co	ntributs to	the cause of de	eath?
F.						1 2 Y	s 2 No	3 Prob	ably 4 Unk	known
b o			-	-		-				
leted						24a. Was a	n autopsy ned?	ava	re autopsy findir ilable prior to	
Completed								of d	nplation of causi leath?	ia
Comp						1 D Y	s 2 1 No	1□	Yas 2□ No	
BeC	25. Was case referred to medical				26 Place of D	eath (Check only on	/			
0	examiner?	lospital:	ER/Outpatient 3	B DOA ON	her:	Home 5 ☐ Reside		er (Specify	1)	
T. To	27. Menner of Deeth	28a. Dete of Injury	28b. Time of	28c. Inju Wo		28d. Describe ho				
tion	1 Natural 5 Pending 2 Accident investigation	(Month, Dey Year)	Injury		rk? ]Yas 2∐No					
Medical Certificat	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, farm, street,	factory, office		28f. Location (Si	reet end Numl	ber or Rure	Route Number,	
Certification:	4 Homicide	building, etc. (Specif				City or Town	n, Stete)			
0	29e. Certifier 1 Certifying Phys	sician: To the best of my kno	wledge death occ	curred at the ti	me date end ple	ca and due to the c	suse(s) end m	enner es str	ated.	
edicai		ner: On the basis of exemina and manner stated.								
8	29b. Signature and title of certifier	7		29c. Licens	se number	2	9d. Dete signe	d (Month, L	Dey, Year)	
	11/1				2510	lysnille.	12/10/0	0		
	104ms			D3	0018		40/0			
	30. Name and address of person who co	empleted ceuse of death (Item	n 23a) (Type, Print	(i) V	11	1 - 0	. 1			
	Mr. Herdenet	100 12	ellene.	Mane	Teld	ysnella.	Md.			
State	31. Date filed (Month, Dey, Year)	32. Registrar's Signa	atura La	for.	and I	V				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Yaar Preston Rohrer Stine 21,2000 4:40 pm Dec 4a. Facility Name (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death FAhrney - Keedy Norsing Home Washington Bounsburg 6. Sax 1 M 2 F 7. Aga (In yrs. last birthdav) If Undar 1 Yaar 5. Social Security Number If Undar 24 Hrs. Birthpiaca (State or Foraign Country) 8. Data of Birth (Month, Day, Year) Months Days Hours 90 214-16-0620 July 1, 1910 Maryland Usuai Residence of Decedent 10b. County 10c. City, Town or Location 10d. insida City Limits Hagerstown Md. Washington 1 Yes 2 No 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 345 Antietam Dr. 21742 U.S.A 11. Marital Status 12. Was Dacedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Ricen, etc.) Race - Amarican Indian, Biack, White, atc. Yas 2 No 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No Spacify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Milk Transfer Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) John William Stine Carrie R. Rohrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William P. Stine (Son) 3906 Highland Ave. Myersville, Md. 21773 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec. 24, 1 Burial 2 Cramation 3 Removal from State Beaver Creek Cemetery Beaver Creek, Md. 5 Other (Specify 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final diseasa or condition rasulting in death) Sequentially list conditions, if any, leading to immediate ceusa. Entar Underlying Cause (Diseasa or injury that initieted events resulting in deeth) Last bstructive Polmonary Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to complation of ceuse of death? 24a. Was an eutopsy shat roce 1 Yas 2 No 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation

**Physician** /Medical **Examiner** Tha law requires that the death certificate be axecuted

**Physician** 

/Medical

Examiner

**Funeral Director** 

þ

Be Completed

2

Funeral

Director

Itam 27 is marked other than "natural", or itama 23a or 28a-f show other treumatic event, the Modical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Itam 27 is merked other than "natural", or itar any Injury or other treumatic event

Presten

tha burial-tre be dateched for usa as signed by this cartificata has Aftar within 24 hours eftar death To the Funeral Director: , completely filled in by tha

Division of Vital Records, P.O. Box 68760,

or Attending

death.

Examiner Be Completed by Physician/Medical Medical Certification: To

1 Yes 27. Manner Death Neturat 2 Accident

3 Suicide 4 Homicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as steted.

Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatury 3d

29d. Date signed (Month, Day, Year)
Dec 22, 2000

State Registrar

32. Registrar's Signature

He Books koro, MO 21713-1844

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 42710

			Cen	tificate of	Death	R	eg. No.		
Physiciar	1. Decedent'a Name (First, Middle, Last,					2. Dete of Dee Month	th Dey 1	Yeer	3. Time of Death
/Medica	eagene wearing					Decemb			0345 An
Examiner	4a Facility Name (If not institution, give Washington Cou			-101	4b. City, Town, or L		4c. County		114
	5. Social Security Number 6. Sec		last hirthday)	If Under 1 Year	Hagers to			ring to	VL ace (State or Foreign
Funeral Director	220-16-2853 X	M 2□ F 86	Yrs.	Months Deys	Hours Min.	8. Date of Birth (Month, Day Dec. 26	, 1914	Countr	yland
72 hours after death with the Meryland netural", or items 23s or 28s-1 show deat Experies must be notified at	Usuat Residence of Decedent  10a. Stete 10b. County	10c. Cit	ty, Town or Loc	ation				10	d. Inside City Limits
deny	Md. Washingt	on	Smith	sburg					1 ☐ Yes 2 ☑ No
or 28a-f show	10e. Street and Number			10f. Zip Code		1	0g. Citizen of \	What Countr	y?
terna 23a or 28a-f sho wer must be notified at	23734 Mong Rd.			21	783		u.s.	Α.	for the
or items 23s	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. W	/as Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-		e - America	
if, or items 23s or 28s-fs caroline must be notified	1 Never Merried 2 Merried 3 Widowed 4 Divorced	1 Yes 2 No		☐ Yes 2 🕅 No		7 110411, 010.)	Specify	test *	
			16a. Decede	ent's Usual Occu	petion		16b. Kind of B	usiness/Indu	ustry
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ygiene. Nethen neturi	12		t	armer			Fari		
H OF A	17. Father's Name (First, Middle, Last)				18. Mother's Nam			ne)	
Men			1			Mae Ria	-		
h and raun	19a. tnformant's Name/Relationship (T) Arvel J. Barrett	(Friend)			p Dr. Haq				J00e)
ther	20a. Method of Disposition	20b. I	Place of Dispos	ition (Name of	Ī		20c. Location		m. State
ry or o	Buriel 2 Cremetion 3 4 Dogation 5 Other (Specify)	Ternoval from State	cemetery, crem	atory or other pla Cemetery		29,2000			
importa any inju pnce.	21. Signature of Funeral Service Aicens		22.	Name and Addre	ess of Facility	12525 B	radhuri	1 Aug	- 31
SEES	mouries &	- Para	> Vo	ives tun	eral Home	Smithsb			
	23a Pert1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the deel	th. Do not ente	r the mode of dy	ing, such es cardiac				Approximete Interval Between
ysician '									Onset and Death
Medical xaminer	Immediate Cause (Final disease or condition	PNEUM	LONIA						50
	resulting in death)	Due to (	or as a consequ						
Je it		CONGES	TIVB	HEART	FAILL	PE			17
al-tra	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c. C FRONIC	or es a consequ	ience of):	Ω			1	
ng physician and tas the burial-transit	Cause (Disease or injury that initiated events	C 4 RONIC	OBSTR or es e consequ	DCT IVE	PULMO	NARY	DISEAS	E	204
s th	resulting in death) Last	4	or es e consequ	ierice or).					
		GOUT						1	20>
the ett	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the un	derlying cause gi	iven in Part I.	23b. Did t	obacco use co	ntributa to	the cause of death
d by the ettend letached for us	DARKING	2.5 1.10	10-			101	es 2□ No	3 Prob	ably 4 Unknow
be del	PARKINSO	INS DISER	136					_	
ate has been signed by the ettend page 2 should be detached for us	DENTIA					24a. Wes a perfor		ava	re autopsy findings ilable prior to
200	JEIVITA .		201					of d	pletion of cause eath?
page	HYPOTHYO	ROIDISM				1 🗆 Y	es 2 No	1 🗆	Yes 2□ No
actor B	25. Wes case referred to medicat exeminer?	January.		0		th (Check only o	10)		
SEP F	TE TOS ZEE NO		ER/Outpatient	3LI DUA		ome 5 Resid			)
octor: After by the funer	27. Manner of Death  1 1 Natural 5 Pending Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of tnjury	M 1	ork? ]Yes 2 □ No	28d. Describe h	ow injury occur	160	
y the	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	nome farm stre			28f. Location (S	treet and Num	ber or Rural	Route Number,
Dir.	4 Homicide determined	building, etc. (Speci		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tow	n, Stete)		
within 24 hours siter death.  To the Funeral Director: After the completely filled in by the funeral Medical Cartification.	29e. Certifier 1 Certifying Phys	sician: To the best of my kno	owledge, death	occurred at the t	ime, dete and place	, and due to the o	ause(s) and m	anner as sta	ated.
n 24 he Fu pletel	(Check only 2 Medicat Exami	ner: On the basis of examina and manner stated.	ation end/or inv	estigetion, in my	opinion, death occu	rred at the time, o	late and place,	and due to	the cause(s)
Tott	29b. Signature end title of certifier	0		29c. Licen	se number	-	29d. Date signe		
	minc	ter		05	2323		12/	26/00	
	30. Name end eddress of person who co	ompleted ceuse of death (Iter	m 23a) (Type, F	Print)	1	-			
	Dr Waseem	14414 CL	eiter	sburg	rike H	agers	town	Ma	ry land
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	1	1	1			1

from to species

060 % 2000

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certificate	e of I	Death		Reg. No.		
	1. Decedent's Name (First, Middle, I						2. Dete of D		Voor	3. Time of Death
hysician	Catherin	e Barbara	Schmit	t			Decem	ber <sup>Day</sup> , 2	2000	2:21 AM
Medical xaminer	4a Facility Neme (If not institution, g	ive street and number	)		4		or Location of Dea			
	Frederick Mem	orial Hosp	ital			Frede	rick	Fred	lerick	C
ineral rector	5. Sociel Security Number 217-22-4561	Sex 7. A 1□ M 2以 F	ge (In yrs. last birti 94 Y	hday) If Under Months	1 Year Deys	If Under 24 H Hours M	Irs. 8. Date of B	ey, Year 906	9. Birthp	lace (State or Foreign Tand
	Usual Residence of Decedent		I							
notified at rector	Maryland Freder	ick	Frede:					10d. Inside City		
at be notified at Director	10e. Street and Number 30 North Plac	e		10f. Zip	217	01		U.S.A		ntry?
by Funeral	11. Maritat Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1  Yes XX If Yes, Give Yeer or Detes:	?	13. Was Deceded If Yes, special 1 Yes	ify Cuba	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	Ble	ce - Americ ck, White, by: White	etc.
	15. Decedent's (Specify only highest (	Education	168.	Decedent's Usual	Occup	etion	wakina	16b. Kind of B	usiness/In	dustry
Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Book Binder  17. Fether's Name (First Middle Lest)						, and the same of	Book B	Bindir	ng
No traumatic	Henry Hammerbacher						Neme (First, Middle y Teres			
	19e. Informent's Name/Reletionship Mary T. Martin,	(Type, Print) Daughter	19b. 6	Meiling Address 937 Mead	(Street OW	and Number or Lake Ro	Aurai Route Num ad, New	Market,	, State, Zip Md • 2	21774
	20a. Method of Disposition  1  Buriel 2 Cremetion 3  4  Donetion 5  Other (Special Control of Contr		cemeter	Disposition (Name, crematory or of	her plac		Date 2000	20c. Location		own, State , Maryland
any inju	21. Signature of Funeral Service Nice		M00255	Keeney	Addre an	ss of Fecility d Basfo	rd P.A.	Funeral	Home	
	23e. Pert1. Enter the disease, or co shock, or heart feiture. List on	mplications that cause ly one cause on each	d the death. Do n line.							Approximate Intervel Between Onset and Deeth
ian ical iner	Immediate Cause (Final disease or condition		Coronary	Artery	Dis	ease				Years
	resulting in deeth)		Due to (or es e c			513	The sales			
nine	The Haster of the	b	Hyperten						1	
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ia E	Cause (Disease or Injury	с	HyperLip						1	
use es tre burat-transit	resulting in death) Last	d	Due to (or es a co	onsequenca or):						
Physician	Pert II. Other significant conditions	contributing to death	but not resulting In	the underlying ca	use giv	ven in Pert 1.	23b. Dt	d tobacco use co	ontribute to	o the cause of death?
by Phy	Aortic S	tenosis-Cr	itical				1[	Yes 3 No	3□ Pro	bably 4 Unknow
Completed by F	Osteoper	osos					24e. We per	es en eutopsy rformed?	av	ere autopsy findings allable prior to ampletion of cause death?
Com							10	Yes 2X No	1[	□ Yes 2□ No
D CO	25. Wes case referred to medical exeminer?	Hospital:			01	or:	Deeth (Check onl)			
2	1 ☐ Yes 2 █ No	Hospitel: 1 Inpat	4 44 4	petient 3 DO		4 Li tanisin	g Home 5 □ Re			<b>y</b> )
ertification:	27. Menner of Deeth  1 Netural 5 Pending  2 Accident investiget		ay Year) 28b. T	Ime of 21 njury M	Bc. Injur Wor	ry et rk? Yes 2□No	28d. Describ	e how injury occu	11 <b>9</b> 0	
d in by the	3 Sulcide 6 Could not determine	Zee. Pleca of in	njury - At home, far tc. (Specify)	m, street, factory	, offica		28f. Location City or 7	(Street and Num fown, Stete)	ber or Run	al Route Number,

29e. Certifier

1XXCertifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) end menner stated.

D 47556

29c. License number 29d. Date signed (Month, Day, Year)

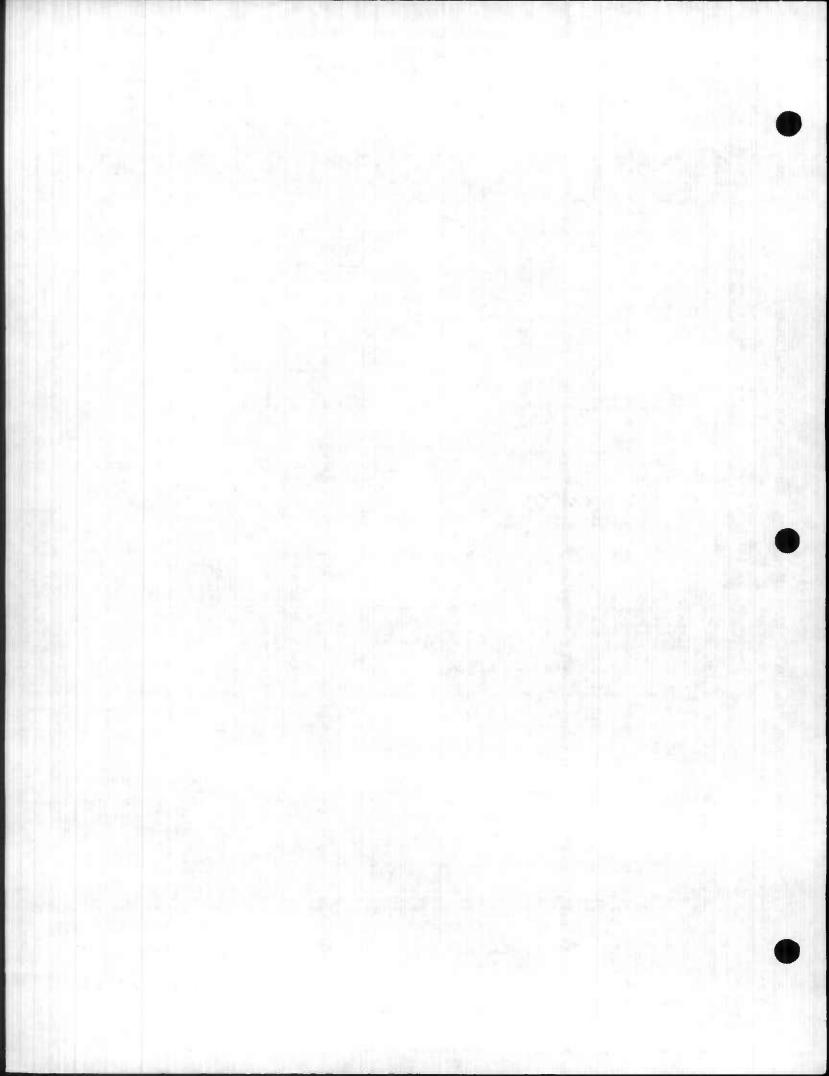
December 4, 2000

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

William H. Johnson, M.D., 172 Thomas Johnson Drive, Frederick, Maryland 21702

State Registrar

31. Dete filed (Month, Day, Year) 32. Registrar's Signeture DEC 0 8 200p



Physician /Medical	1. Decedent's Name (First, Middle,	Last)				2. Data of Death		3. Time of Death
/Medical	EFFIE REBE	CCA STOTTL	EMYER			Month DECEMBER	Day Y	par 00 1913
Examiner	4a Facility Name (If not Institution,	give street and number)			4b. City, Town, or L		4c. County of	
Examine	Washington Cou	inty Hospit	a1		Hagerstow	n	Washir	igton
Funeral	5. Social Security Number 6		(In yrs. last birthday)	If Undar 1 Yaar		8. Date of Birth	(201) 9	Birthplace (State or Foreign Country)
Director	213-84-4255	1 M 2 F	82 Yrs.	Months Deys	Hours Min.	July 29,	1918	Maryland
9	Usual Residence of Decedent							
appara	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
oto oto	Maryland Freder	ick	Myersvil	le		1 ☐ Yas 2½		
death with the Maryland ris 23e or 28e-f show creat be notified at neral Director	10e. Street and Number	_		10f. Zip Code		10	g. Citizen of Wha	at Country?
12 E E E	12324 Loy Wolfe	Road		2177	73		USA	
	11. Marital Status	12. Was Decedant E Armed Forcas?	Evar in U,S. 13.	Was Decedent of I If Yas, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puarto	ecify Yes or No- Rican, etc.)		American Indien, White, etc.
by by	1 ☐ Never Married 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	lo	1 ☐ Yas 2 🖺 No			Specify:	White
ed within 72 ho ygiene. er then "netur t, the Medical Completed	15. Decedent's (Specify only highest	Education grade completed)	18a. Deced	dent's Usual Occu	pation during most of work	ina 1	6b. Kind of Busin	ness/industry
up du	Elementery/Secondary (0-12)	Coilege (1-4or 5	+)		during most of work ed)			
Co the	7		Hom	emaker			Own Hom	le
B worth	17. Father's Neme (First, Middle, La	ist)				a (First, Middle, Mi		
To To	Noah Eccard			VIII III	Amy Ali	ce Miller	r	
and and	19a. Intorment's Name/Relationship				t end Number or Rui			
227 84 Tr	Frank V. Stottle	myer, Sr. /	_		Wolfe Roa	d, Myersy	ville, M	D 21773
ant of He nt: If Ben ry or oth	20a. Method of Disposition  1 🖾 Burial 2 🗆 Cramation 3  4 🗆 Donation _5 🗀 Other (Spe		20b. Piece of Dispo cametery, crer Salem Unit	netary or other ple	odist 12			ny or Town, Steta lle, Maryland
and and and and and and and and and and	21. Signature of Funeral Service Lie	cerisee	22	2. Name and Addre	ess of Facility	504	Main St	root
O THE SE	1441	1 his	R	icketts 1	Funeral Ho			MD 21773
	23a. Part1. Enter theirdisease on o	unlications that caused						Approximete
1	23a. Part1. Enter the disease on a shock, or heart failure. List or	one ceuse on each lin	10.	or the mode of dy	ang, out at tartat	or roupilotory office	.,	Intervel Between Onset and Death
hysician /Medical	Immediate Cause (Finel	0		0				721
xaminer	disease or condition resulting in deeth)		ATERAL		10 NIA			12 hours
- O			Due to (or as a consec	quence of):				
n and ist-transit		b						
iten/Medical Exan	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	British II	Due to (or es a consec	quence of):				
trending physician and or use as the burial-transit land.	cause. Enter Underlying Cause (Diseese or injury thet initiated events	c						
tending physicism ruse as the burnant an/Medical	resulting in death) Last		Dua to (or as a conseq	juanca of):				1
ding se as		<b>d</b>						
		. FEVER						
ned by the at detached for y Physici	Pert II. Other significant conditions	contributing to death bu	at not resulting in the u	nderlying cause gi	iven in Part I.			ibute to the cause of death
deta deta	MULTIPE	E OSTE	ED POROTIC	VENTE	BRAL	1 Ye	• 2⊡No 3	Probably 4 Unknow
0 00	Table 5 (1) 1 (1) 1 (1) 1 (1)					240 14100	e udones:	24b. Were eutopsy findings
page 2 should Completed	FRI	ROSIS				24e. Wes an perform		available prior to completion of cause
has b								of deeth?
Page Page	OG 190 DO.	ROSIS				1 ☐ Yes	2 No	1 Yes 2 No
this certificate ral director, pa	25. Wes case referred to medical axaminer?					th (Check only one	)	
die o	1 Yes 2 No	Hospital:	nt 2□ER/Outpatier	1 3LI DOA		ome 5 Resider	nce 6 Other	(Specify)
5 E -	27. Manner of Deeth 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, De)	Year) 28b. Time of Injury	f 28c. Inju	ury at ork?	28d. Describe how	w injury occurred	
ter this neral d		tion			Yas 2□No			
ath. r: After ne fune atlon	2 ☐ Accident Investiga		28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)  28f. Location (Street and Number or Rural Route No. City or Town, Stete)					
ath. re fune atlon	2 Accident and Suicide 6 Could no determin	ed 200. Flaca of Inju		reet, factory, offica		28f. Location (Str. City or Town,	eet and Number Stete)	or Rural Route Number,
Attention	3   Suicide 6   Could no determin	ed 200. Flaca of Inju	(Specify) of my knowledge, deet	n occurred at tha t	time, dete and place,	City or Town,	Stete) use(s) end menn	er es stated.

29b. Signature, and tole of Certifier

29d. Data signed (Month, Day, Year)

and address of person who completed cause of deeth (Item 23a) (Type, Print)

22911

SM ITMSISING FMD 21783

State Registra

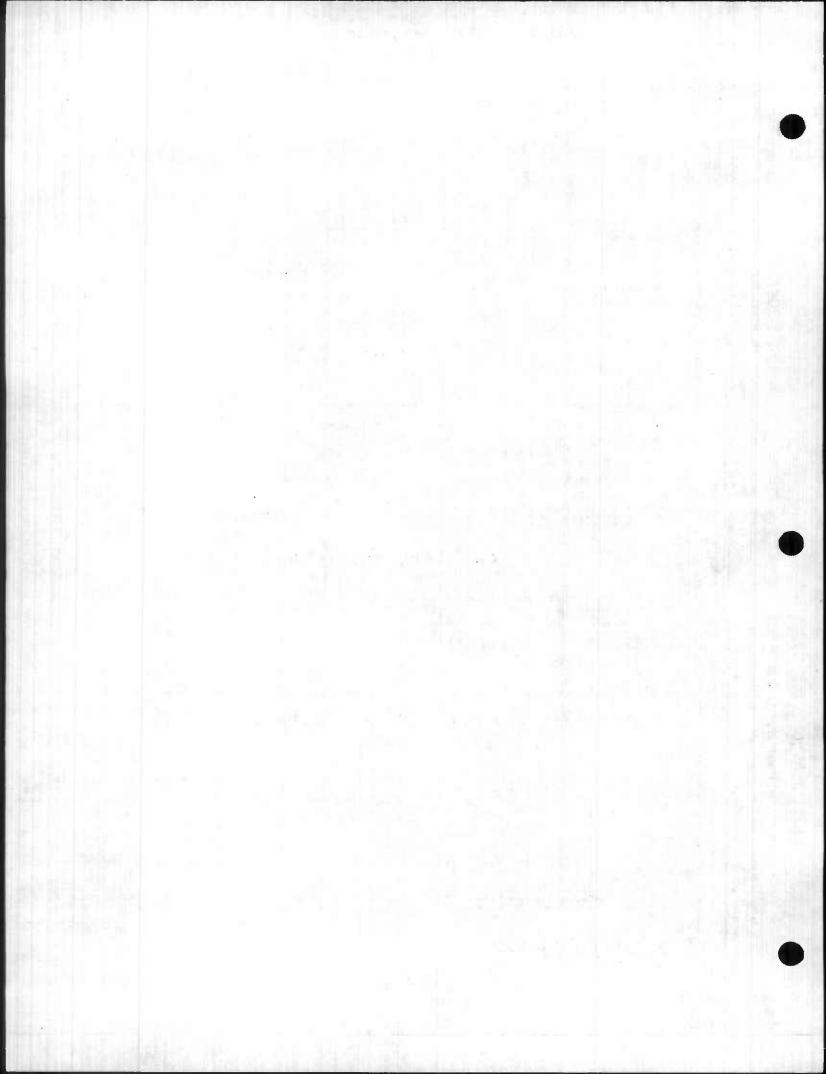
STOTTLEMYER, EFFIE

\$1. Date Hed (Month, Dey, Year) 32. Registrar's Signature DEC



DHMH 16 Rev 6/95

**ORIGINAL** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 2. Data of Death 3. Time of Death Month Day Year DEC 2000 13

Examiner **Funeral** 

Director must be notified at

death with the Meryland r than "natural", or items the Medical Examiner ma filed within 72 hours efter of Hygiene. other than "natural", or iter Peges 1 and 2 should be filed nent of Health and Mental Hygi-nt: If Item 27 is marked other traumatic event, other 1 ò permit. Pege Department of Important: If any Injury or once.

Baltimore, Maryland 21215-0020

**Physician** /Medical Examiner

that the death certificate be executed physician end s the burief-transit ettending p use as signed by the et d be detached for peeu page 2 has certificate this funeral After death. ie Hospital or Attandii n 24 hours efter death. ie Funaral Diractor: A pletely filled in by the fu To the Hosp within 24 hou To the Funa completely fi

P.O. Box 68760.

Records,

Division of Vital

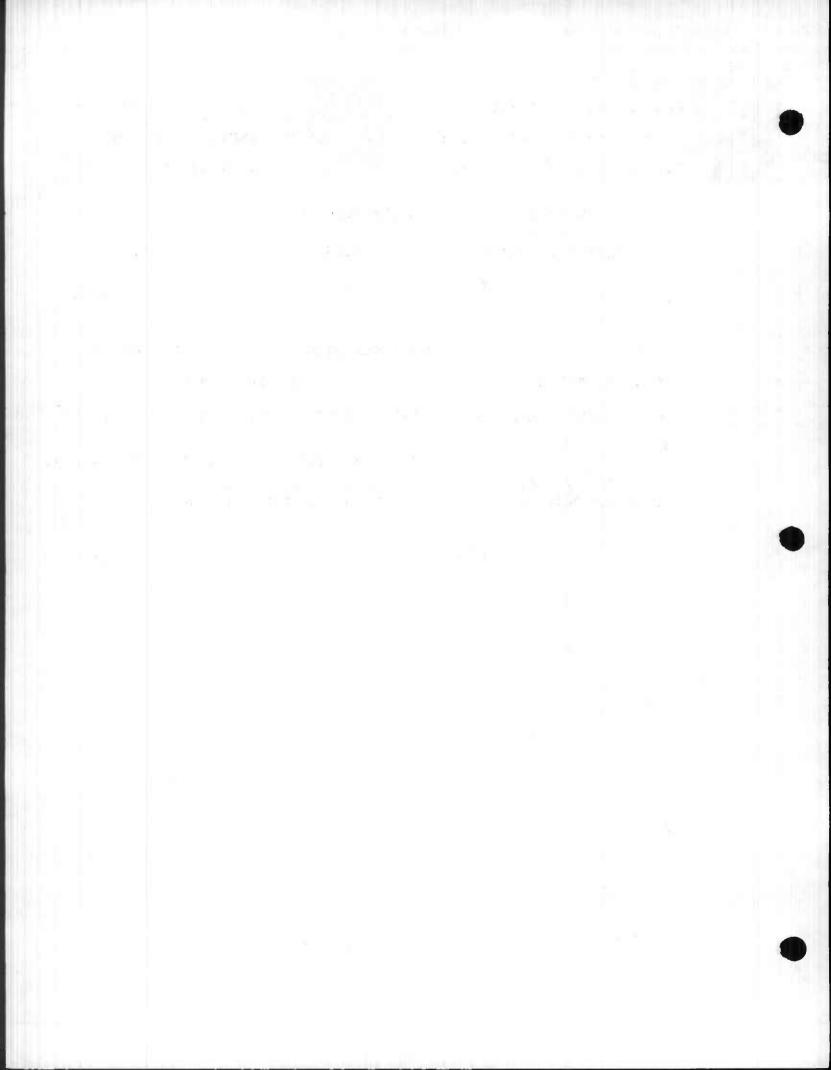
1. Decedent's Name (First, Middle Last) **Physician** CHARLES NEWTON STAUB 12:40 am /Medical 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death CENTER GAITHERSBURG MONTGOMERY WILSON HEALTH CARE If Under 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Dey, )

ULY 28 5. Social Sacurity Number 7. Age (In yrs. lest birthday) Birthplace (Steta or Foreign Country) 1**X**M 2□ F 218-14-0617 80 Yrs. MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYas 2 □ No Director MONTGOMERY MONTGOMERY VILLAGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20305 MARKETREE PLACE 20886 U.S.A. Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whifa, atc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: WHITE þ 3 Widowed 4 □ Divorcad Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondary (0-12) College (1-4or 5+) 11 BUSINESS OWNER RESTAURANT 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Meiden Sumeme, GEORGE A. STAUB JENNIE C. BUTLER 19b. Mailing Address (Street end Numbar or Rural Route Number, City or Town, Stete, Zip Code) 20886 20305 MARKETREE PL., MONTGOMERY VILLAGE, 19a. Informant's Neme/Relationship (Type, Print) CHARLES STAUB, JR / SON 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Surial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 12/16 BEALLSVILLE, MD MONOCACY CEMETERY 22. Name and Addrass of Facility HILTON FUNERAL HOME Part1. Enfer the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. MD 20838 Approximata interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequenca of) Examiner Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initioted events resulting in death) Last Due to (or as a consequenca of) Physician/Medical Dua to (or as a consequence of): Part II. Other aggnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending Investigation 1 Natural 1 Yes 2 No 2 ☐ Accident 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier 29b. Signatury and title of cartifier 29c. License numbar 29d. Data signed (Month, Dey, Year) e and address of person who completed cause of death (Item 23a) (Type, Print) 9410 Old Georgetown Rd, Betherda minos

State Registrar 31. Date filed (Month, Day, Yeer)

32. Registrar's Signature

1 4 2000



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

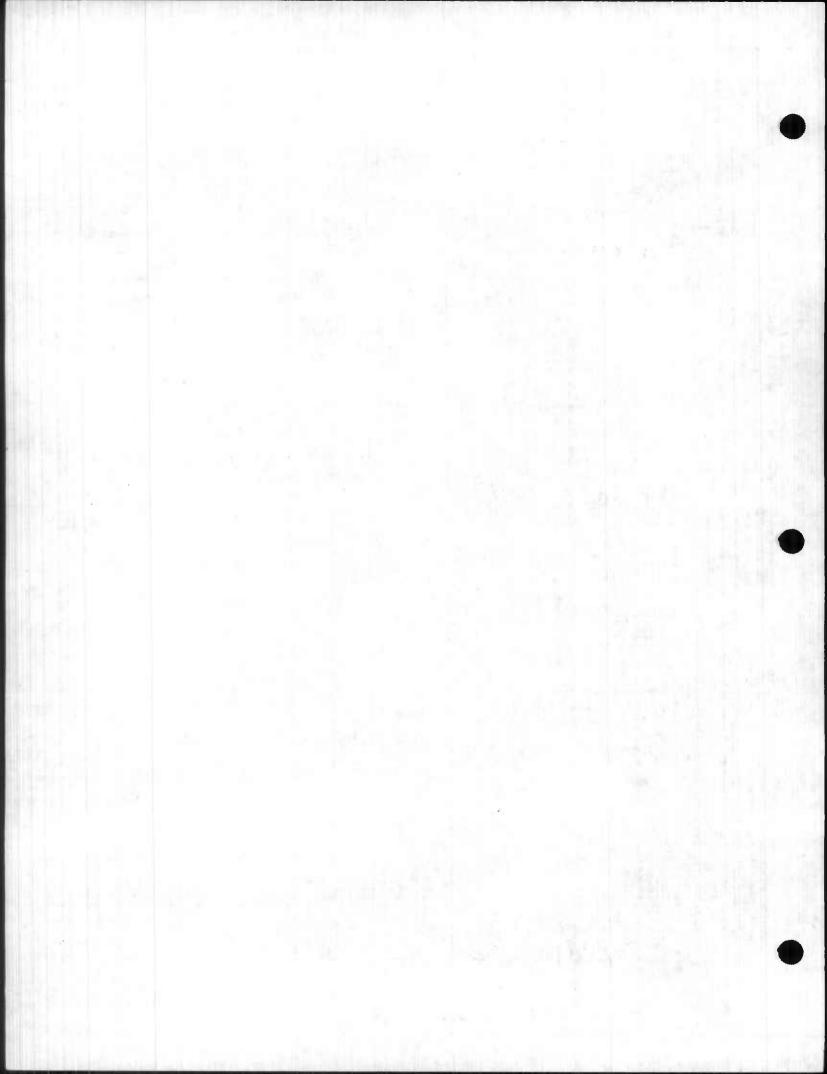
State of Maryland / Department of Health and Mental Hygiene 0 4 2 7 1 4

			Certificate of	Death	Reg. No.	hoe / f	
	Physician	Decedent's Neme (First, Middle, Last)	2701	2. Dete of D	Dev Yeer	3. Tima of Death	
	/Medical		SUSA	DECEM	BER 13, 2000		
	Examiner	4e Fecility Neme (If not institution, give street end number) Frederick Memorial Hospita	al	4b. City, Town, or Location of Dec Frederick	4c. County of Deeth Frederic		
	Funeral Director	227-28-5928 1 M 3 T F 7	3 Yrs. lest birthday) If Under 1 Year Months Deys		girth Year) 9. Birth 9. Co. Virg	nplece (State or Foreign unity) 31n1a	
	the Maryland 28a-f show notified at	Usuel Residence of Decedent  10a. Stete 10b. County 10b  Maryland Frederick 10b	c. City, Town or Location Monrovia			10d. Inside City Limits 1 ☐ Yes 2 HO	
	E 02 0	10e. Street and Number 12443 Fingerboard Road	10f. Zip Code 21770	0	U.S.A.		
980	urs after death aft, or items 23 Exempler meat by Funeral	11. Maritel Stetus  1 Never Merried 2 Merried  3 Widowed 4 Divorced  12. Wes Decedent Ever Armed Forces?  1 Yes \$\times\$ No if Yes, Give Yeer or Detes:	in U,S. 13. Wes Decedent of If Yes, specify Cul	Hispanic Origin? (Specify Yes or I ban, Mexican, Puerto Rican, etc.) Specify:	No- 14. Race - Amer Black, White Specify:		
21215-0036	od within 72 ho yglene, we then "netur it, the Medical Completed	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondery (0-12)  College (1-4or 5+)	16a. Decedent's Usuel Occu (Give kind of work done life. DO NOT use retin Homemaker	ipetion e during most of working ed)	16b. Kind of Business/i		
Maryland	Mental Hy wheel other stic event.	17. Fether's Neme (First, Middle, Last)	nt Bowers	18. Mother's Neme (First, Midd Sylvia E. Sh			
	nd 2 sho lith and 27 is my r traum	19e. Informent's Neme/Reletionship (Type, Print) Eddie Susa, Son		board Rd., Monro			
Saltimore,	Pages 1 a ent of Hea nt. if Nem ry or othe	\$778	Ob. Placa of Disposition (Name of cemetery, cremetory or other placements). Brethren Cer	Date Date metery, Dec. 16, 200	20c. Location - City or To Mt. Solon,		
Balti	Departm Departm Importa any Inju	21. Signeture of Funeral Service Licensee	AGE E	nd Basford P.A.			
	Physician	23a. Pert1. Enter the disease, or complications that caused the shock, or heart fellure. List only one cause on each line.	IUU Dast	Church St., Free ring, such as cardiec or respiretory	errest,	Approximete Intervel Between Onset end Deeth	
۱	/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	to (or es a consequence of);		1 1 1	7 W1344	
	be executed leian and burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause, (Disease or Injury	to (or as a consequence of):	100		200 000	
Box 68760,	ifficate be ng physicia as the bu	resulting in deeth) Last	to (or es e consequenca of):				
	death certies at for use	Pert It. Other significant conditions contributing to death but no	ot resulting in the underlying cause of	iven in Pert f. 23b. Di	d tobacco use contribute	to the cause of death?	
, P.O	the the	CVA, PERIPHERAL	VASCULANT		No 3 Pr	robably 4 Unknown	
Records,	ew requir	DISEASE, ATRIA	E FIBRILLA		rformed?	Were eutopsy tindings available prior to completion of cause of death?	
Vital R	certificate he rector, page	25. Wes case referred to medical		1[ 26. Plece of Death (Check on)		1 ☐ Yes 2 ☐ No	
- N		examiner?  1 Yes 22 No Hospitel: 1 Hospitel:	2 ER/Outpatient 3 DOA	ther: 4 Nursing Home 5 Re		cify)	
n of	F = 5	27. Menner of Deeth  Y Netural  5 Pending  28e. Dete of Injury (Month, Dey Ye			e how injury occurred		
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After templetely filled in by the funer Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Placa of Injury building, etc. (S	At home, ferm, street, fectory, office		n (Street end Number or Ru Town, State)	ural Route Number,	
	Hospita 24 hours Funeral etely fille	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of me one of the desired from the desired from and menner steted.	y knowledge, deeth occurred et the minetion and/or investigation, in my	time, date end pleca, and due to the opinion, deeth occurred et the time	na cause(s) and manner es e, date end place, and due	stated. to the cause(s)	
	vithin To the comple	29b. Signature and title of certifier	29c. Licer	nse number	29d. Date signed (Month	7000	
		30. Name and address of person who completed cause of deeth Boyd Dwyer, M.D., 170	(Item 23a) (Type, Print) Thomas Johnson I	Drive, # 10, Fre	derick, Md.	21702	
		Doyd Dwycz, III.D., 170					

State Registrar

DHMH 16 Rev 6/95

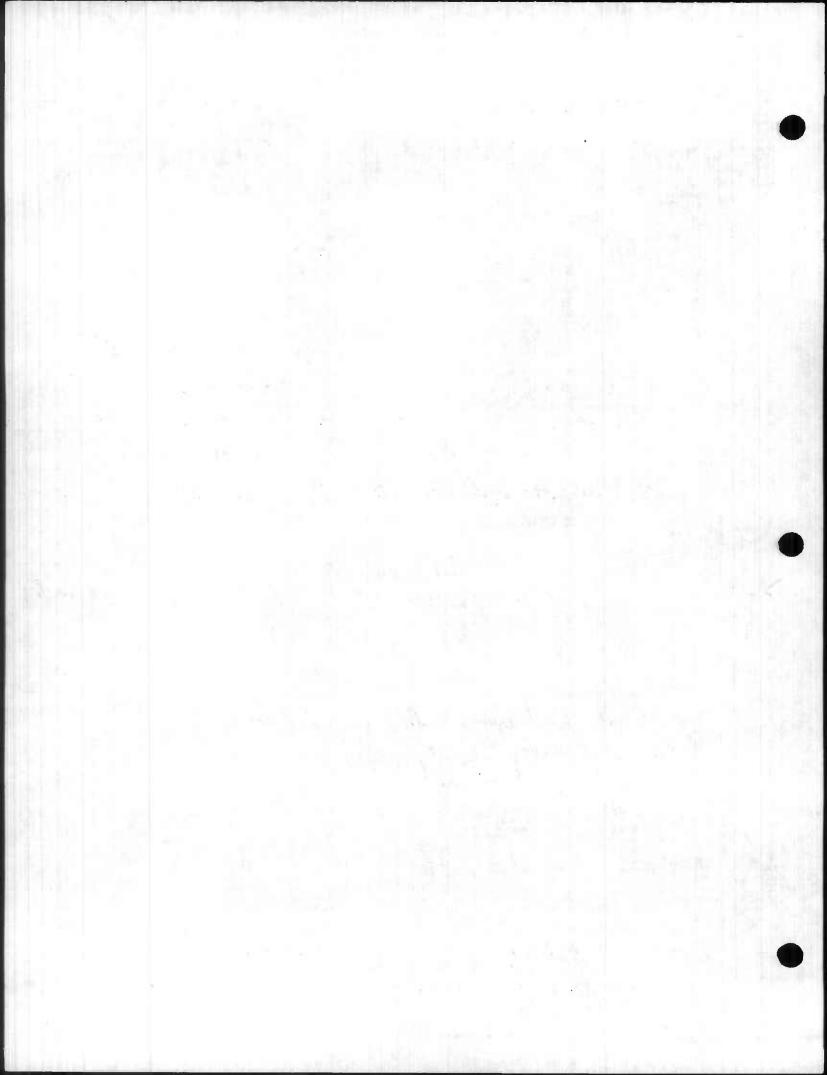
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### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4.2.7.1.5

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month December 14,2000 **Physician** William Edgar Spring 2:45PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year)
August 3 1939 If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Deys 1 M 2 □ F Months 214-36-0142 61 Frederick MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County d other than "natural", or hams 23s or 28s-f show event, the Medical Examiner must be notified at Frederick Knoxville 1 Yes 2000 Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4116A Petersville Road 21718 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indian. Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: hq White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiens. J & M Drywall Elementery/Secondary (0-12) College (1-4or 5+) Drywall Mechanic Frederick, MD 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) should be is marked William Edgar Spring, Sr. Nellie Mae Butler 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health at Heart 27 is 4116A Petersville Road, Knoxville, MD Hazel A. Spring, Wife Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Pages 1 1X Buriel 2 ☐ Cremetion 3 ☐ Removal from State Frederick, MD Resthaven Memorial Gardens 12/18 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, Barbara A. Williams, Owner 21716 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician Immediate Ceuse (Finel disease or condition resulting in death) /Medical Mmasta Examiner que to for as e consequence of): Examiner ( a signed by the attending physician and d be detached for use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enfer Underlying Cause (Disease or injury Due to (or as e consequence of): certificate be execu Physician/Medical thef initiated events resulting in death) Lest Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by Division of Vital Records. The law requires 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? After this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Cena eral Director: After this certific filled in by the funeral director, Be 25. Wes case may 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 DER/Outpetient 3 ☐ DOA NO No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 27. Mener of Death Ne Naturel 28b. Time of Injury 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? Attending 5 Pending investigation 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) or A effer 4 Homicide To the Hospital of within 24 hours even To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dev. Year) 29c. License number 29b. Signeture end title of certifier W no completed cause of death (Item 23e) (Type, Print) VICI. 1475 31. Dete filed (Month 32. Registrer's Signeture State oaks Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Stryker Philip 11:35 PM December 18 2000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins HOSPITAL Baltimore Johns If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 17 M 2□ F Yrs Director 141-24-2863 Usual Residence of Deceden New\_Jersey with the Maryland 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Director W. Va. Jefferson Harpers Ferry 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than any Injury or other trainment. 234 Route 5, Box 120 Funeral 25425 USA 12. Wes Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. Black, White, atc. 1 ☐ Yes 2 ☑ No If Yes, Give ☐ Year or Datas: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast greda completed) Elementery/Secondary (0-12) College (1-4or 5+) Publisher Publishing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surnama) Be William Bradford Stryker Lytie Katherine Fuller 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2800 Pacific View Drive - Corona Del Mar, CA 92625 of Disposition (Name of Date 20c. Location - City or Town, State Lorna S. Donovan - Sister 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 12/20/00 Hagerstown, Maryland 21. Signature of Funerel Service License 22. Nama and Addrass of Facility Eackles-Spencer Funeral Home 23a. Pert1. Entar the diseasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. 0 Harpers Ferry, WV 25425 Approximata Intarval Between Onset end Death **Physician** Immediate Causa (Final diseese or condition resulting in death) /Medical Acute Mycloid one month Examiner Physician/Medical Examiner Myclodysplastic The law requires that the death certificate be axecuted the bunal-trans Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last and Due to (or es e consequence of) Box 68760, attending physician Due to (or as e consequence of) USB as 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, à 24b. Ware autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Be Completed page 1 ☐ Yes 2 No 1 Tes Physician: the funeral director. 25. Was cese referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 ☐ Yes 2 No 1 ■ Inpatiant 2 □ ER/Outpatiant 3 □ DOA edical Certification: To 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury et Work? Division 5 Pending investigation or Attending 1 Neturel 1 Yes 2 No 24 hours after death. 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. completaly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the ceuse(s) end manner stated. (Check only one) within 2 To the 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number December, 18, 2000 ter M.D RES-000 30. Name and address of person who completed cause of daath (Itam 23a) (Type, Print) Johns Hopkins Hospital Baltimore, MD Abenaa Brewster 31. Data filed (Month, Day, Year) DEC 2

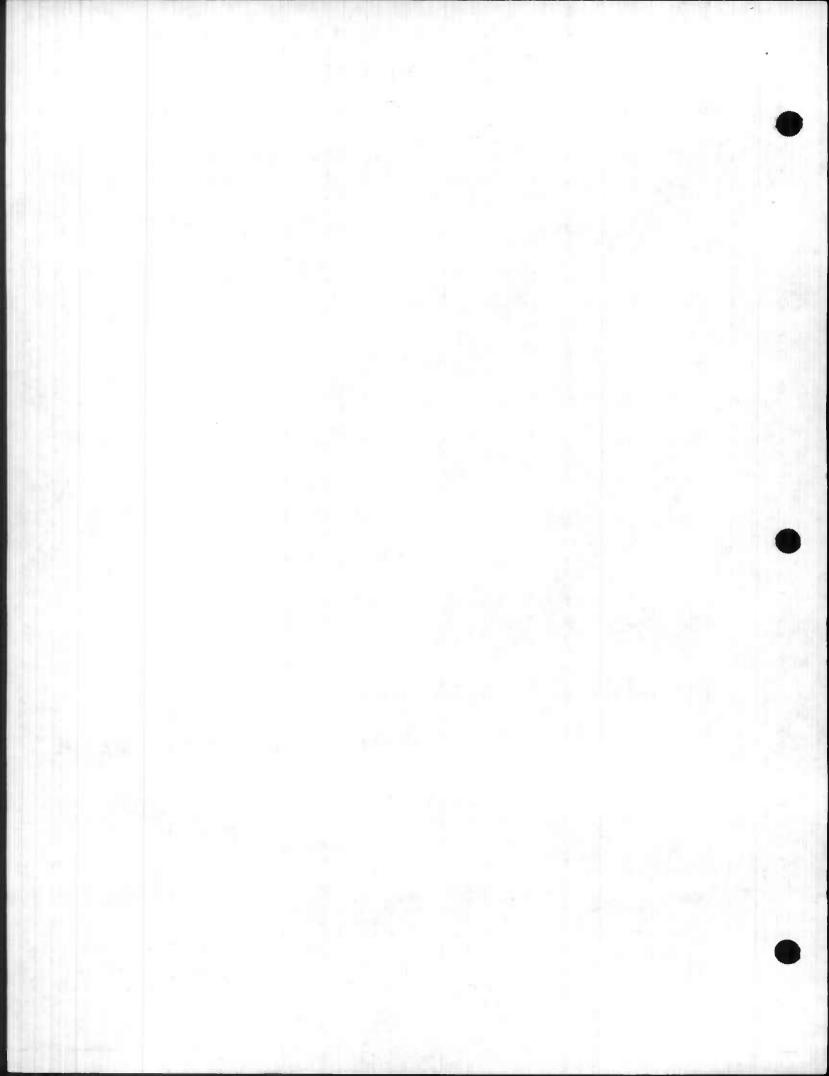
DHMH 16 Rev 6/95

State

Registrar

32. Registrar's Signature

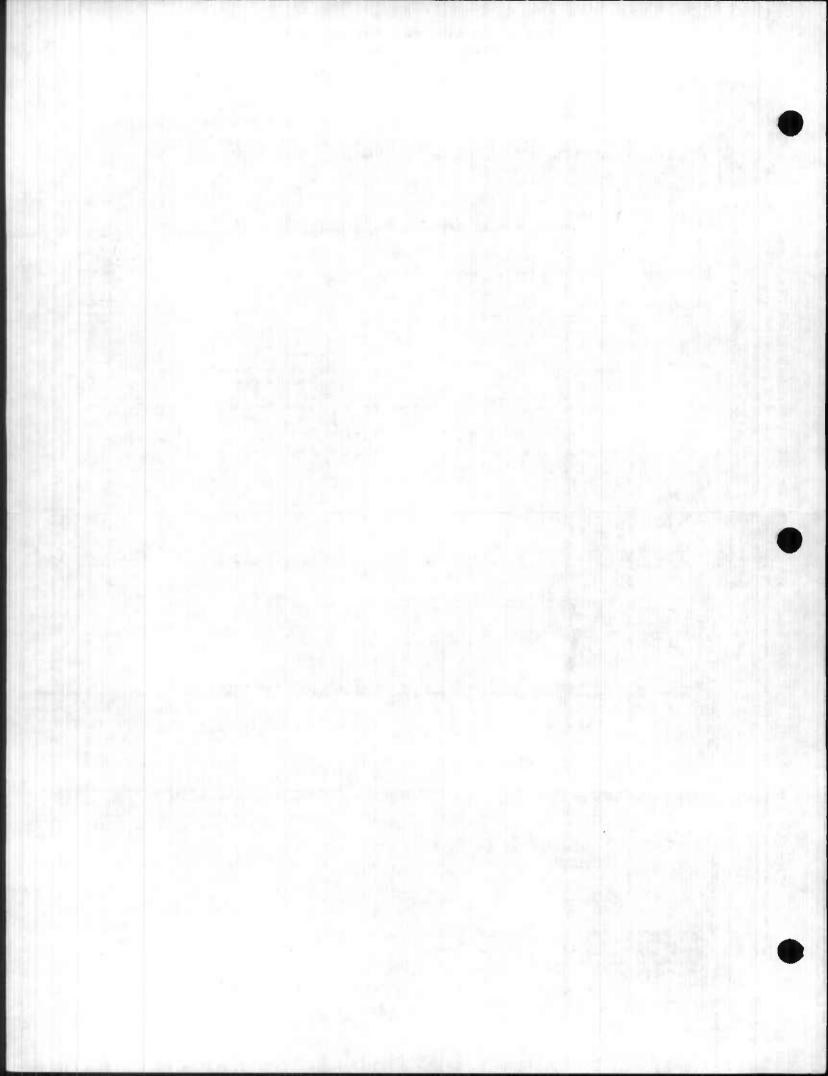
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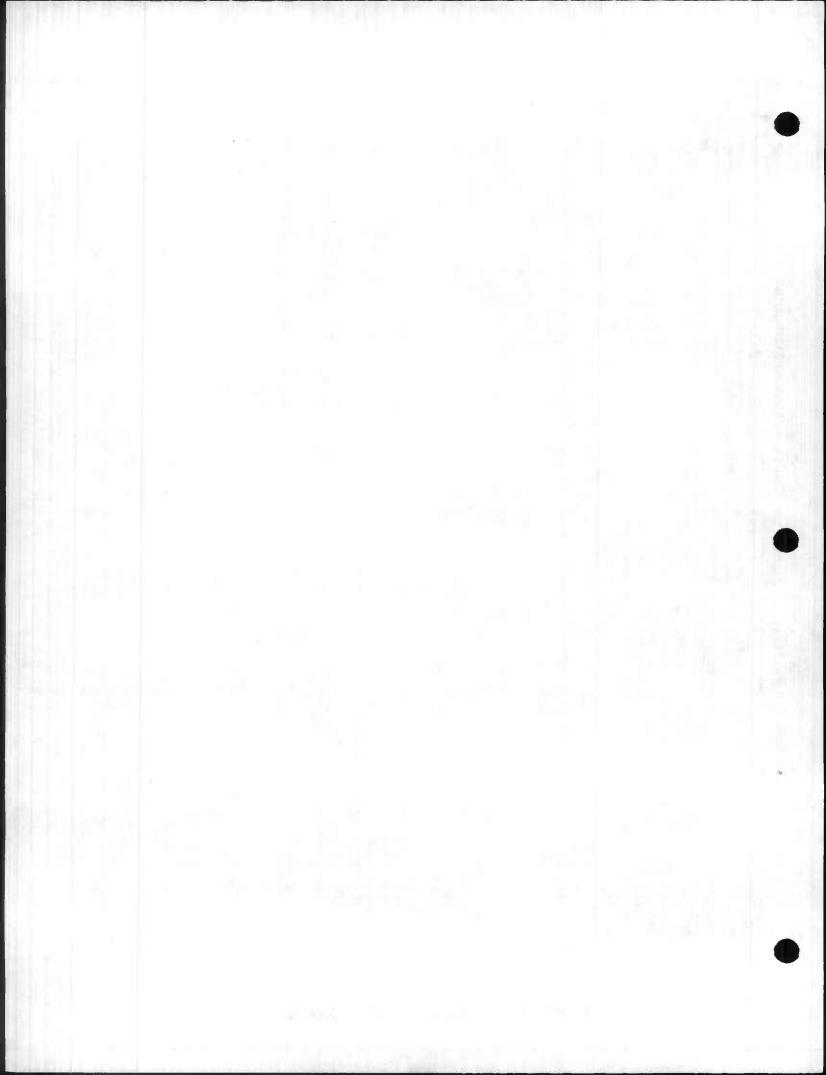
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State of Maryland / Department of Health and Mental Hygiene 0 427 17 Certificate of Death

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day Year December 20, 2000 **Physician** Grace Elizabeth Rowe 8:10 p.m. STONE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7355 F Street Chesapeake Beach Calvert If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2 1 1 F Yrs 220 82 Director 1616 February 28, 1918 Virginia Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location t 0d. Inside City Limits r 28a-f show Inotified at 1 X Yes 2 □ No Director MARYLAND CALVERT CHESAPEAKE BEACH 10a. Street and Number 10f. Zio Code 10g. Citizen of Whet Country? Berns 23a or must be 7355 F STREET 20732 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11. Meritel Stetus Hygiene. other than "natural", or iten ent, the Medical Examiner Black, White, etc. 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be permit. Pages 1 and 2 should be I Department of Health and Montal I Important: If Item 27 is marked of any Injury or other traumatic eve 2 JESSE ROWE BESSIE REDFORD 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ROBERT C. STONE /son same as 10 20b. Plece of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other place) 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 12/28/00 CHELTENHAM, MARYLAND MARYLAND VETERANS 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 22. Neme end Address of Fecility Rausch Funeral Home, Owings, MD 20736 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of), Examiner Planatinde Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): ettending physician tor use as the buria Physician/Medical Due to (or as a consequence of): USB BS signed by the el Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate of Vital Hospital or Attending Physicians director, 25. Was case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this tuneral 27. Menger of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Aftar Division 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion death. 2 Accident within 24 hours after deal To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide edicai 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the ceuse(s) end manner steted. \$ 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 12/22/60 04/3/4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul V. Pomilla, M.D. Solomons, 20688 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State DEC 2 2 2000 > Registrar



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH O Miriam 1005 12 horne 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH
(Month, Day, Year)
5 - 27 - 05 IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State 1 - M 2 X F 033-16-0251 Newfoundland Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH CollegeView Nursing Center Frederick Frederick DIRECTOR 10b. COUNTY 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY Md. Frederick Smithsburg 1 - YES 2 X NO permit. 10e. STREET AND NUMBER FUNERAL 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit 13748 John Cline Rd. 21783 U.S.A. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, OIVE WAR OR DATES 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married 1 TYES 2 TYNO Specify: White BY Specify: 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION secilly only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Sp College (1-4 or 5+) Nurse Hospital 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Joseph J. Thorne Elizabeth Milley BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 13748 John Cline Rd. Smithsburg, Md. 21783 Jean A. Wright (Niece-in-Law) pe 20a. METHOD OF DISPOSITION
1 □ Burlel 2 □ Cremation 3 □ Remo
4 □ Departor 5 □ Other (Specify) DATE 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must Smithsburg Crematory Dec. 19,2000 Smithsburg, Md. the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSI 22. NAME AND ADDRESS OF FACILITY 12525 Bradbury Ave. Davis Funeral Home ernis Smithsburg, Md. completely filled in by the rial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellura. List only one cause on each line. Interval Batween been signed by the attending physician and completely filled in it. of Health and Mental Hygiene prior to burial, cremation, or IMMEDIATE CAUSE (Final Onset and Death Yneumonia 7 DAYS other traumatic event, resulting in death) requires that the death certificate be executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate e. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated evente resulting in death) LAST 6 PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? Demention shows any 1 - YES 2 NO OF DEATH? Seizure Plaorder 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN has b 23 HOSPITAL OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate to the State HOSPITAL: 1 - YES 2 NO OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) marked, or 27. MANNER OF DEATH 28a, DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED with w 1 Natural 1 YES 2 NO DIRECTOR: After the hours after death v BY 2 Accident 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 09 COMPLETED 8 Could not be 28 4 Homicide Hem 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. TO THE HOSPITAL
TO THE FUNERAL (
DE filed within 72 h
IMPORTANT; If II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. BE asuyran 40307 > 20 Dec OU 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Eugene B. Casagrande M.D. 3000 Ventrie Ct. Myersville, Md. 21773 31. DATE FILED (Month, Day, Year) 32. REGISTRUR'S SIGNATURE DEC 2 6 2000 boarder



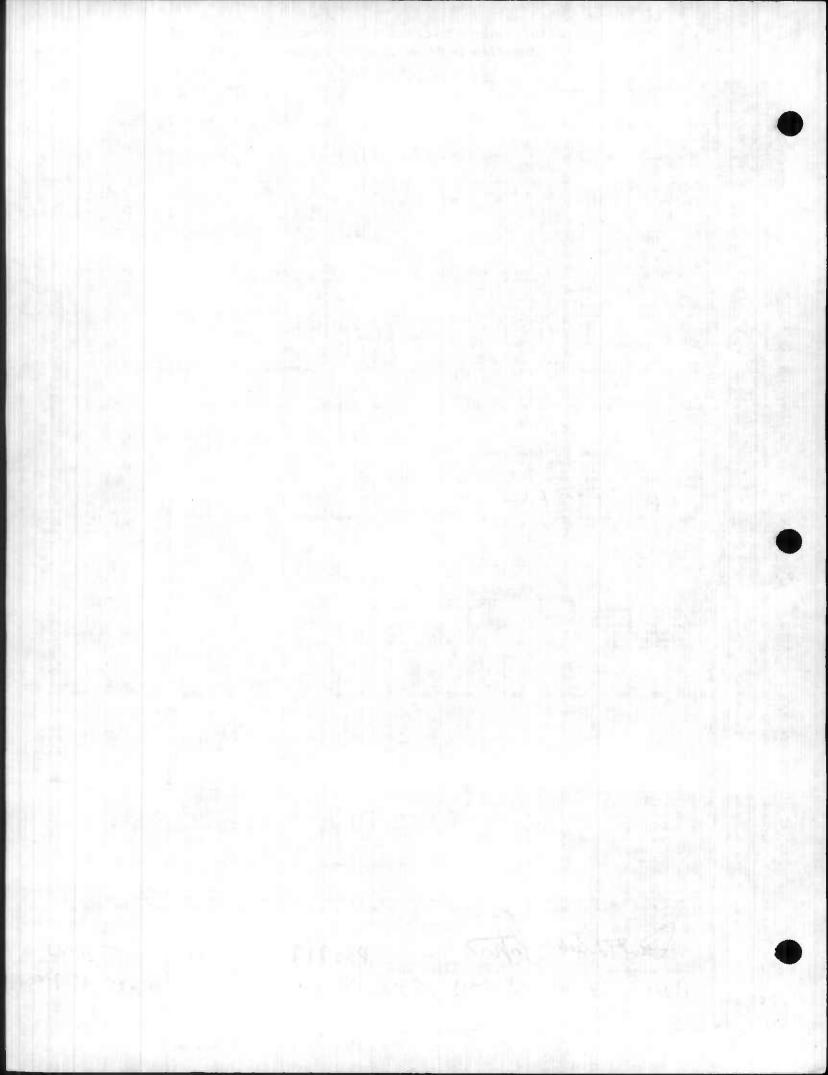
State of Maryland / Department of Health and Mental Hygiene

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			C	ertificate of	Death		Reg. No.	1 60
	1. Decedent's Name (First, Middle, L.	st)	PM 1 2 12			2. Dete of D		3. Time of Death
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/Medica	do Facility Name (Mass in estitution of	ve street and number)			4b. City, Town,	, or Location of Dea		
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			(In yrs. lest birthde	(v) If Under 1 Yea	Rockv		irth	ntgomery  9. Birthplace (State or Foreign
Funeral	305-24-4950	11X1 M 2□ F	71 Yrs.	Months Days	s Hours I	June 1	3, 1929	Country) Indiana
Director	Usuel Residence of Decedent		/1			pulle 1.	3, 1727	Ilidialia
Pu A	10a. Stete 10b. County		10c. City, Town or	Location				10d. Inside City Limits
5-0020 72 hours after death with the Maryland natural; or Itema 23a or 28e-f ehoword in the Example of the profiled at	Maryland Freder:	ick	Mt. Ai	ry				1 ☐ Yes 2 ☑ No
r 28	Maryland Freder:			10f. Zip Code		1 1/20 1	10g. Citizen of V	Whet Country?
Ne Sa	13053 Penn Shop I	Road		217	771		Unite	ed States
Peath 2	11. Marilel Status  1 Never Merried Merried	12. Was Decedent E	ver in U,S. 13	. Wes Decedent of	Hispanic Origin	? (Specify Yes or N	lo- 14. Rec	e - American Indien,
Her o	1 Never Merried 2 Merried	Armed Forces? 1 ☐ Yes 2 No		If Yes, specify Cu	ben, Mexican, P	uerto Rican, etc.)	Bied	ck, White, etc.
21215-0020 d within 72 hours aft giene.	3 Widowed 4 Divorced	If Yes, Give Yeer or Detes:		1 ☐ Yes 22 No	o Specify:		Specify	White
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B Per Per Per Per Per Per Per Per Per Per	POVE	24.11	- 0					Homes, P.A.
		5. 1						Maryland 21771
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/ /Medical Examiner	Immediate Cause (Finel disease or condition	Chronic	Renal Fa	ilure				1 Year
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0 4 5 7		28a. Dete of Injury	28b. Time				e how injury occur	
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Division or Attending after deeth. Director: After d in by the fune	27. Menner of Death  1 020Neturel  2	building, etc.	(Specify)	street, factory, offic	•		own, Stete)	A CI Marer Modie Maniber,
Te si si si si si si si si si si si si si								
Divi	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of miner: On the basis of a	my knowledge, de exemination end/or	eth occurred et the investigation, in my	time, date and p	placa, end due to the courred at the time	e cause(s) end me e, dete and pleca.	enner as stated. end due to the cause(s)
the Hin 24 the Fu		and mulhour stet	ed.					
To the vithin 2 To the comple	29b. Signature end title of gertifier	14	,	29c. Lice	nse number		29d. Date signe	ed (Month, Dey, Year)
	tant Will	couper	/	D33	719		Daomh	05 5 7000
	30. Name and address of person who	completed cause of de	eth (Item 23a) (Tvo	e, Print)	- 1 1		TYCK MILLY	, , , , ,
	Paul T. IN.O.	binski N	10 1960	550 OFF	no Dr	K D	Coithor	SONGHO ? CES
State	31. Dete filed (Month, Dey, Year)	32. Registre	s Signeture	1000	uc for	1100	Ocu LIE	1000
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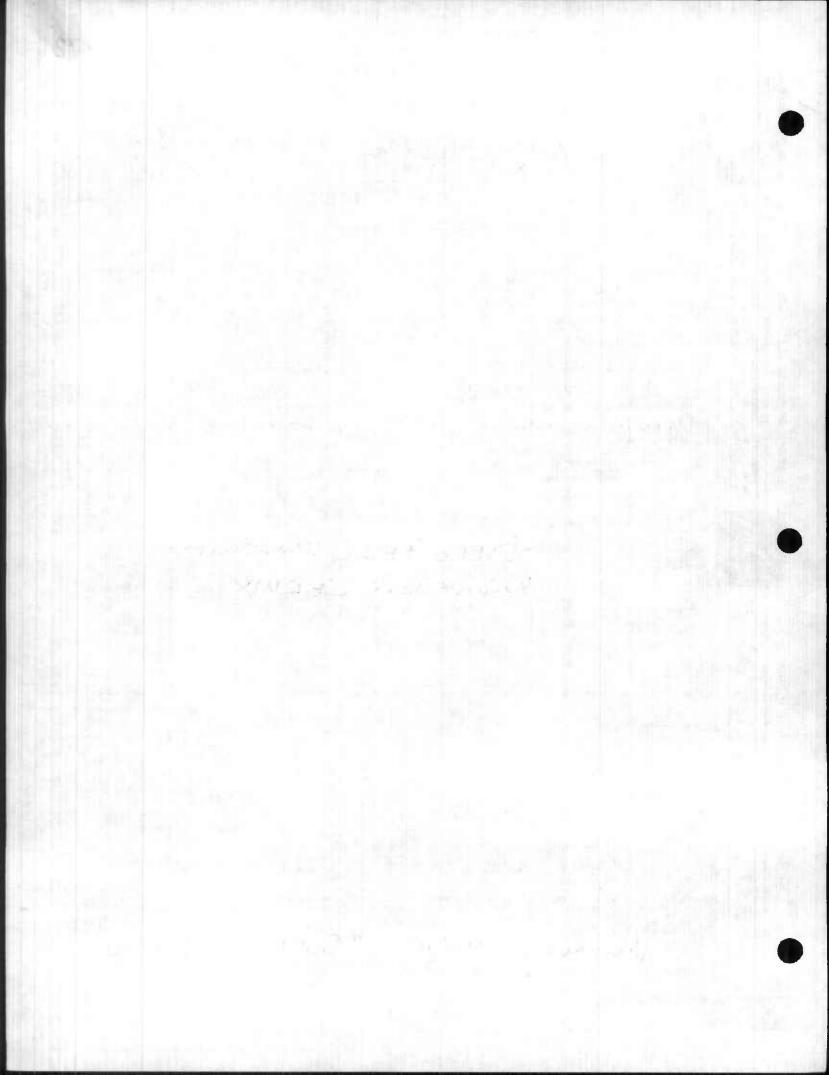
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 4 2 7 2 1

					Certifica	ate of	Death	Re	g. No.		
		1. Decedent's Name (First, Middle, Last	)	14.0%				2. Date of Deat		Van	3. Time of Death
Physic		LINDSAY CAT	THERINE	TA	HOR			Month / Q	Day	Yeer	1042
/Medi Exami		4e Facility Neme (If not institution, give	1101-11	11	0011		b. City, Town, or	Location of Deeth	4c. County	of Death	70 / 0
LAUIII	iici	CARRALL COUNT	Y GEN I	HOSP	ITAI		Westr	INSTER	PA	RROI	//
		5. Social Security Number 6. Se	7. Age (I	In yrs. last birt	hday) If Un	der 1 Year	If Under 24 Hrs	8. Date of Birth	Ch	9. Birthot	ace (State or Foreign
Funeral Director		10	M 25 F	_	Yrs. Month	ns Days	Hours Min.	(Month Day	5 · 00	Count	MM
Director		Usuel Residence of Decedent					10,0	100	1.00		1110
a a		10a. Stete 10b. County	11	Oc. City, Town	or Location					10	Od. Inside City Limits
Show and a	5	Manual and Campall		Ma A							1X Yes 2 □ No
1 e 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	oct	Maryland   Carroll		Mt. A		~ ~ .					
£ 6	Director	10e. Street and Number			107.	Zip Code		1	0g. Citizen of W	nat Count	ry r
23 th	8	1407 Summer Sweet	Lane			2177	1		United	State	es
72 hours after death with the Menyland "natural", or flams 23a or 28a-f show ideal Examinet must be notified at	Funeral	11. Maritel Stetus	12. Wes Decedent Eve Armed Forces?	er in U,S.	13. Was De	cedent of F	lispanic Origin? (San, Mexican, Puer	pecify Yes or No-		- America	
or ft		1 Never Married 2 Merried	1 ☐ Yes 2 ☒ No If Yes, Give								
E	by	3 Widowed 4 Divorced	Yeer or Detes:		10 103	s 2∏ No	Specify:		Specify:	wn:	ite
72 hours at natural, or dical Exam	Completed	15. Decedent's Edu	cation	16a.	Decedent's U	Isual Occup	ation		16b. Kind of Bu	siness/Ind	ustry
	ble	(Specify only highest grad			life. DO NO	work done T use retired	during most of wo	rking			
filed within Hygiena. ther than	E	Elementary/Secondery (0-12)	College (1-4or 5+)	-	none						
		17. Father's Name (First, Middle, Last)			none		18. Mother's Na	me (First, Middle, M	Aaiden Sumame	)	
d 2 should be filed th end Mentel Hygi the marked other traumatic avent,	Be C	Victor love	TAYLOR				8/10	10 Cat	HERIN	e T	Avlas
should nd Men merke	To	19a. Intormant's Name/Relationship (T)		106	Mailing Adds	nac /Strant	CHAIN	ural Route Number			Code
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00-1		20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 ☐ F		cemeter	y, cremetory	or other ple			20c. Location - (	ity or Tov	wn, Stete
mit. Peges 1 partmant of He portant: If Item y Injury or others.		4 Donetion 5 □ Other (Specify)	ioniova nom otato	Mt. 01	ivet C	emete	ry	12/9/00	Frederi	ck, N	Maryland
permit. Peg Department Important: I any injury once.		21. Signeture of Funeral Service Licens	88	K HH	22. Name	end Addre	ss of Fecility S +	auffer Fu	neral H	Omes	РΔ
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		220 Parti Fatastha disease assembly	instinue that accord th	a death Day				lvd., Mt.			21771
		23a. Pert1. Enter the disease, or compleshock, or heart failure. List only of	ne cause on each line.	e deeth. Do n	iot enter the n	node of dyli	ig, such es cardia	c or respiratory em	351,	1	Approximete Intervel Between Onset and Death
Physician			0			) De	1 10.00	0.00			Onset and Death
/Medical Examiner		Immediate Cause (Finat disease or condition	DENE	212	TEI	AL	(10,1000)	TIMS, E			
Examine	ы	resulting in death)	Du	e to (or as a c	consequenca				40.34		
D #	Je l		N COI	WHY.	new	· C	BRV	IX			
tha daeth certificate be executed y the attending physician and ached for use es the bunial-transit	Examin	Sequentially list conditions.	)	e to (or as a c	consequence	ot):					
an an an inal-t		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury									
ficate be e physician st the buria	edical	that initiated events	)	e to for es e o	onsequence of	of).					
ng phy es th	8	resulting in death) Last	500	0 10 (0) 00 0 0	orisoquoriso (	J. 7.					
Certi	3		d								
attendin for use	100										
ha de	Physician	Part II. Other significant conditions con	tributing to death but n	not resulting in	the underlyin	ng cause giv	ren in Part I.	23b. Did to	bacco uas con	tribute to	the causs of death?
of the	4							1 U Y	98 2 No	3 Prob	ably 4 Unknown
requires thet the da	by										
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law re las be	Completed									соп	npletion of cause death?
The law ate has pege 2	Ē							100	s 2 No		Yes 2 No
F # 0.								1 🗆 Ye	,	1.	Tes ZU NO
sician: The certificate irector, per	Be	25. Was case reterred to medical examiner?	lospital:			DOA Oth		ath (Check only on	8)		
Physician: rthis certific	2	TLI Tes ZONNO	1 Inpatient	2□ ER/Ou	`	DOA	4 U Nuising i	fome 5 ☐ Reside			)
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l or Attanding after death. Director: After d in by the fune	at	2 ☐ Accident investigation			M	10	Yes 2 No				
or Attend after death Director: / d in by the	E E	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, tai	rm, street, tac	tory, offica		28t. Location (St City or Town		or or Rural	Route Number,
s after al Direct by Direc	Certification:		33	-2				,			
To the Hospital o within 24 hours af To the Funeral Di completaly filled is	18	29a. Cartifier 1 Certifying Phys	sician: To the best of m	ny knowledge	, death occurr	ed at the tir	ne, date and place	and due to the ca	ause(s) and mai	nner as at	ated.
Ho Fu	edical	(Check only 2   Medicat Exami	for: On the basis of ex and manner stated	camination and	d/or investigat	tion, in my c	pinion, death occi	urred at the time, d	ate and placa, s	nd due to	the cause(s)
ithin o the ompl	Me	296. Signature and title of pertifier	1			29c. Licens	e number	2	9d. Date signed	(Month, I	Dey, Year)
F 3 F 8		1 11 1	Mhu	4/ W	2	No	30191		12-00		
		1 hours	7.0			Vi	10111		14.00	2,0	0
		30. Neme and address of person who co	mpleted cause of deat	th (Item 23a) (	Type, Print)						
		Dr. Melvin Yeshn	ik / 200	Memori	al Ave	., We	stminste	r, MD 21	157		
St	ate	31. Date tiled (Month, Day, Year)	32. Registrar's		1.	-	34				
Regist	_	DEC 0 8	711111 1 204	neva	D	1200	Ma!				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Month Year **Physician** Richard WILT December 23,2000 0459 a.m. Anthony /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Sacred Heart Hospital Cumberland If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 8. Sex If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 11 M 2□ F Months Days Yrs. Director 215-36-7848 60 Maryland Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow 7 is marked other than "natural", or flams 23s or 28s-f show traumatic event, the Medical Exement must be notined at 1 ☐ Yes 2 No Director Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14705 N. Bell Air Dr. SW 21502 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forcas?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours efter 1 Never Married 2 → Married permit. Pages 1 and 2 should be filed within 72 hours eft. Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or any injury or other traumatic event, the factor from any injury or other traumatic event, the factor from 1 Ves MINO Specify à 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Coal Miner Coal Mining 8th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Ruth JAMISON Naomi Arthur Martin WILT 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14705 N. BEl Air Dr. SW, Cumberland, MD 21502 Laura J. Wilt/ WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from Stete
4 Donetion 5 Other (Specify) 12/26/00 Aurora, WV Aurora Cemetery 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility Stewart Funeral Home any Ir 32 S. Second St., Oakland, MD 21550 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) SUDDEN Abom - 1 HR Examiner Due to (or es e consequenca of): Physician/Medical Examiner 11 YRS URONARY ARTERY requires that the deeth certificate be executed attending physician and for use as the burial-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequenca of) USB as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3Ø Probably 4 ☐ Unknown signed by 1 ☐ Yee 2 ☐ No STRIBER PIBRERANN by 24b. Were autopsy findings available prior to completion of cause of death? should t 24e. Was en eutopsy performed? Completed CONGESTIVE HEART FAILURE page 2 certificate has The OBSTANTINE LUNG DISEKA 1 ☐ Yes A No 1 ☐ Yes 2 ☐ No CHRUNIC Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2/10 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No After this 28a. Dete of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Netural 5 Pending investigation deeth. 1 Yes 2 No eral Director: A 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) after 4 I Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier Herde 26907 December 2 3 2000 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Hariit S. Sidhu M.D. 925 Bishop Walsh Rd., Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar

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DEC 27 2000 / --- / . / Love

	4 Decided Nove (First 18)	#- t A\		Certificate o	Dealli		g. No.		0 T- 1D	. 12
Physician	Decedant's Nama (First, Midd     MILDRED	MITCHELI		TTAYW		2. Data of Death Month 12 /	Day	Year 2000	3. Tima of Dec 8:20	
/Medical Examiner	4a Facility Nama (If not institution	on, give street and number	er)		4b. City, Town, or		4c. Count		0120	P 01
LAMITIME	Wicomico Nu	rsing Hom	e		Salisbu	ırv	Wico	mico		
Funeral Director	5. Social Sacurity Number 216–40–2557		Aga (In yrs. last bi	irthday) If Under 1 Ya Months Day	ar   If Under 24 Hrs	•		9. Birthple	aca (State or Fo	reign
	Usual Rasidance of Dacadant					7.00			7	
M 11	10a. Stata 10b. County	Y	10c. City, Tov	vn or Location				10	d. Inside City L	imits
to find	Maryland Wi	comico	Sal	lisbury					1 Yas 28	JNo
7.284	10e. Street and Number			10f. Zip Code	)	10	g. Citizen of	What Count	ry?	
3a o	Mallard La	nding		218	04		USA			
at, or items 23a or 28a-f show Examiner must be notified at by Funeral Director	11, Marital Status	12. Was Deceda	nt Evar in U,S.	13. Was Decedent of if Yes, specify Co	Hispanic Origin? (S	pecify Yes or No-	14. Ra	ce - America	n Indian,	
F P	1 ☐ Nevar Marriad 2 ☐ Mai	Armed Forca		The second second		o Rican, atc.)	Bla	ck, Whita, a	tc.	
Hygiene.  Hygien	3 ☑ Widowad 4 ☐ Divorce	If Yas Giva		1□ Yas 2₺N	o Specify:		Specif	y: Wh	nite	
natural; or sales Exam leted by F	15. Deceda	nt's Education	168	a. Decedent's Usual Occ	cupation	. 1	6b. Kind of B	usinass/Ind	ustry	
D e	(Specify only highs Elementary/Secondary (0-12)	est grade completed)  Collega (1-4c	or 5.1)	Decedent's Usual Occ (Give kind of work dor life. DO NOT use ret	ne during most of wo ired)	rking				
the Co	11	2	1 34)	Homemaker			Dome	stic		
od other than "nature event, tra Medical Be Completed	17. Fathar's Nema (First, Middle	, Last)			18. Mothar's Nar	na (First, Middle, M	aiden Sumar	ne)		
	Edward De	nwood Mite	chell		Marth	na Ellen	Mess	ick		
	19a. Intormant's Name/Ralation	ship (Type, Print)	19	b. Meiling Address (Stre	et and Number or Ri	ural Route Number,	City or Town	Stete, Zip	Code)	
27 is	William E. Wy	att/Son		1118 Rive	rside Dr.	Salisbu	cv, MD	2180	1	
PES	20a. Mathod of Disposition	,	20b. Place	of Disposition (Name of ery, crematory or other p			Oc. Location			
int: If its	1 ☐ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Othar (		a	ons Cemeter		12/23/00	Sal	isbur	z. MD	
	21. Signature of Funaral Service		Talbe	22. Nama end Add	-	12/25/00	Dai	I DOUL	y / LID	
Departrumporta any inju	To Cot	-in			Funeral	Home Profe	ession	al As	sociatio	on
	Novid A.	changeson !	101051	501 Snow	Hill Rd.	, Salisbu	ry, MD			
	23a. Part1. Entar tha disaasa, o shock, or haart teilure. Lis	r complications that caus t only ona causa on aach	ed tha daath. Do lina.	not entar tha moda of c	lying, such as cardia	or raspiratory arre	st,		Approximata Interval Betwee	
nysician		000	r /	hope	06	2 (	7		Onset and Deal	in.
Medical xaminer	Immediate Ceuse (Final disaase or condition	Chd -	tage 1	huller	ele V	Rucko	ma	1 5	1 Mr	7
	rasulting in daath)		Due to (or as a	consequence of):		/		1		
n and tel-transit Examiner		- h				,		i		
tran tran	Sequentially list conditions,		Dua to (or as a	consequence of):						
	Sequentially list conditions, if any, laading to immadiate cause. Enter Undarlying Cause (Diseasa or injury that initiated avants									
physical s the bu	that initiated avants rasulting in daath) Last	C	Dua to (or as a	consequence of):				1		
0 0 0	Table in State in East									
andre use		d						1		
sicis	Part II. Other significant conditi	ons contributing to daath	but not resulting.	in the underlying cause	given in Part I.	23b. Did tot	acco use co	ontribute to	the cause of d	eath'
als has been signed by the attending page 2 should be detached for use Completed by Physician/N	Senile I	Temente	i, &	ssentia	e	1□ Ye	2 Z) No	3 Prob	ebly 4□Uni	know
ad by	01 7	1 -	21		-	24a. Was an	autonev	24b Wa	re autopsy tindi	nos
shoul	Syperles	esen y	type	rale	mea,	perform	ed?	ava	ilable prior to apletion of caus	
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Page Co.	Jublue	al Ste	malo	mai Her	erthypoed	1 ☐ Ye	s 2 No	1 🗆	Yas 218 No	
10 A	25. Was casa ratarred to medica	al		/ //	26. Place of De	eth (Check only one	)			

Division of Vital

HIGHER MUDIT

ŏ 25. Was casa ratarred to medical axaminer? 8 Medical Certification: To 27. Mannar of Death

To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

State Registrar

1 Yas 2 No

1 ANatural 2 ☐ Accidant

3 Suicide

29a. Certifier (Check only ane)

4 - Homicida

28a. Date of tnjury (Month, Day Year)

28b. Tima of

28a. Placa of Injury - At homa, tarm, street, factory, office building, atc. (Specify)

Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA

29c. License number

1 Yes 2 No

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, data and place, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner stated. 29d. Data signed (Month, Day, Year)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Nama and address of person who completed cause of daeth (Item 23a) (Type, Print)

5302 Chinaberry Drive Salisbury MD 21801 Gregorio Belloso

31. Data tiled (Month, Par Year) 2 2 2000 32. Registra's Signature

5 Panding invastigation

6 Could not be datarminad

28c. Injury at Work?

filed within 72 hours efter 21215-0020 Maryland Baltimore,

WRIGHT

ANN

Box 68760, P.O. of Vital Records, Division

Amended #7, 12-22-00, wchd, dg Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death DEC. **Physician** 20, 2000 3:10 MARY ANN WRIGHT /Medical 4b. City. Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner WICOMICO SALISBURY CENTER: GENESIS ELDERCARE SALISBURY, MD If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth Old / 22/19 Birthplace (Stata or Foraign (Month, Day, 0/4/22/19 Country) 7. Aga (In yrs. last birthday) 5. Social Security Number Deys Hours 1 M 2 K 74 Yrs. 4/222/1926 217-20-0816 Maryland Usual Residence of Decedent with the Meryland 10c. City, Town or Location 10d. Inside City Limits 10a. Stata 10b. County or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2X No Funeral Director Salisbury Wicomico 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21804 USA 410 Weaver Drive 14. Race - Amarican Indien, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 11. Merital Status 1 ☐ Yas 2 ☐XNo If Yas, Giva 1 Nevar Married 2 Married 1 Yas 2 No Specify Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced white Yaar or Detes: "naturel". 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12 Executive Secretary John Samers & Associates 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Pages 1 and 2 should be nent of Heelth end Mental Mary Richardson Walter Wright Seney, Sr. 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) nt of Heelth e: If Item 27 is 410 Weaver Dr., Salisbury, MD 21804 Robert L. Wright (spouse) other 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stete Data 20a. Mathod of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) eny injury 12/23/00 Hebron, Maryland Soringhill Memory Cardens 22. Name and Addrass of Facility
Holloway Funeral Home, P.A. MOIDSI Chompson 501 Snow Hill Road, Salisbury, MD 21804 Approximata Intarval Batween Onset and Daath 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Physician /Medical Immediata Causa (Final diseasa or condition rasulting in death) Examiner Dua to (or as a consaquance of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last pue Dua to (or as a consequence of) Due to (or es e consequança of): should be deteched Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by à 24b. Wara autopsy findings availabla prior to complation of cause of death? Completed 24a. Wes an autopsy performed? hes 1 Yas 2 No 1 Yes 2 No this certificate or Attending Physician: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of After 1 Maturat 5 Panding after death.

I Director: Aft
d in by the fu 1 Yas invastigation 2 Accident 6 Could not be 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicida To the Hospital of within 24 hours a To the Funerel D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29c. Licansa number 29b. Signatura and title of certif 29d. Deta signad (Month, Day, Year) CL D39813 5DQ 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804 31. Dete filed (Month, Day, Year)
DEC 32. Registrar's Signature 2 2000 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

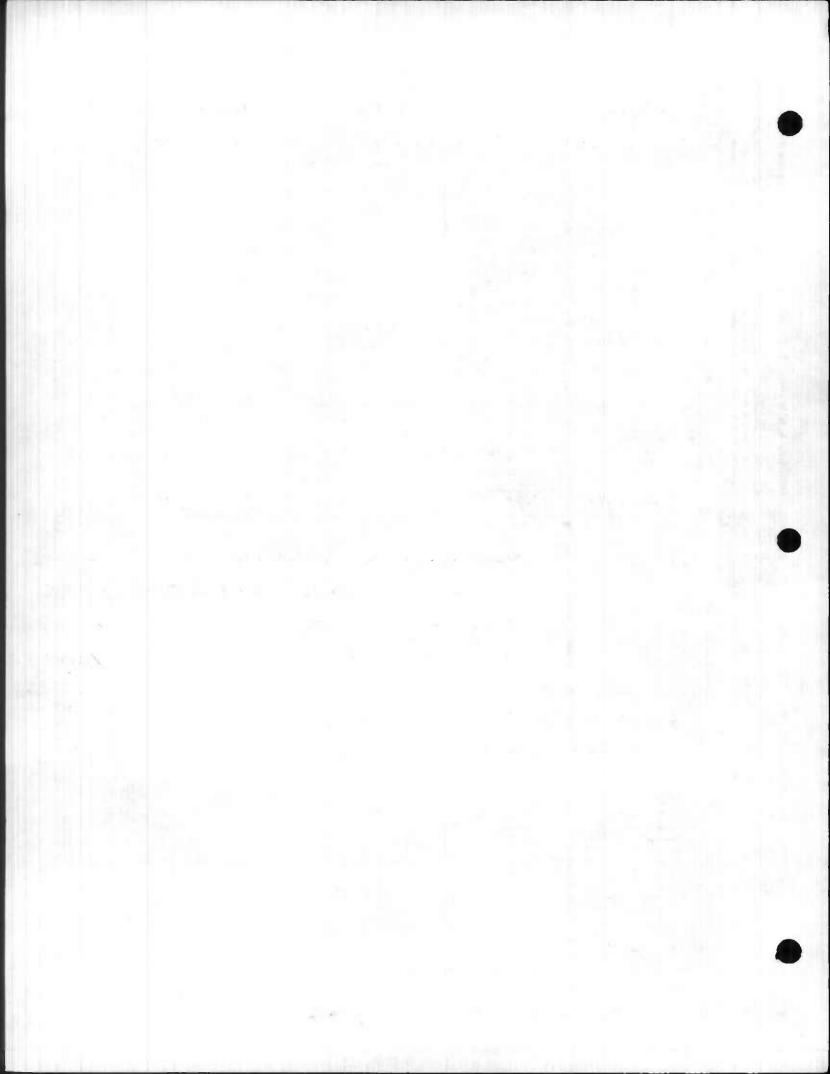
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State of Maryland / Department of Health and Mental Hygiene 00 42725

					Ce	rtificate of	Death		Re	g. No.		- / 22 0
Physici		Decedent's Nama (First, Middle JULIA		KINS		WINGATE			2. Data of Death Month Decembe	Day	Year 2000	3. Time of Death
/Medic Examin	-	4a Facility Name (If not institution PENTINSULA I			AL CENTE			wn, or Lo	cation of Death	4c. County		0
Funeral Director		5. Social Security Number 220–12–0877	6. Sax 1 ☐ M 2 🛣 F	7. Age (In)	vrs. last birthdey, Yrs.	Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Dey, November	Year) 1,1925		leca (State or Foreign try) ryland
Maryland 4 show led.at	lor	Usual Residence of Decedent  10a. Stata 10b. County  Maryland Wicom	nico		City, Town or L						1	0d. Inside City Limits  X□ Yes 2□ No
with the Se or 28s	Direc	10e. Street and Number 1101 Freder	ick Ave.			10f. Zip Code 218	01		10	g. Citizen of N		try?
urs after death	by Funeral	11. Marital Status  1 Never Married 2 XMarri 3 Widowed 4 Divorced	Armed F	2 X No	n U,S. 13.	Was Decedent of H If Yes, specify Cub	an, Mexicar	gin? (Spen, Puerto	ecity Yas or No- Rican, etc.)		ce - Amaricok, Whita,	
21215-0020 3 within 72 hours at pere. • then "neturel", or the Medical Exam	Completed	15. Decedent (Specify only highss Elementery/Secondery (0-12) 12	t grada completed	) (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire cretary	eation during mos d)	t of work	ing 1	6b. Kind of B		dustry
Aland Hardal Hyghertal Hyg	To Be C	17. Fathar's Nama (First, Middla, I Paul Emmons	Hopkins					ary	e (First, Middla, M	laiden Sumen Ones	ne)	
e, Mary 1 and 2 sho Health and 3 en 27 is me ther treams		19a. Informant's Neme/Reletionsh Isaac Howard Wi 20e. Method of Disposition			and .	ing Address (Street  1101 Fred osition (Name of			., Salis		MD 21	.801
L. Pages 1.4 ment of He tant. If Item (ury or other		1 Burial 2 Cremation 4 Donetion 5 Other (Sp.	pecify)	State	cemetery, cre Salisbur	metory or other pla	ory		12/19/00	Sals	sibur	y, MD
Departiment important in		21. Signature of Funeral Service I	fallore	12		501 Snow	Hill	Rd.,	Salisbu	ry, MD		sociation 4
Physician /Medical Examiner	ner	23a 1. Enter the disease, or nock, or heart failure. List of the l		-cia		of 20			or raspiratory arre	st,		Approximate Interval Between Onset and Death
Gox 68/60, death certificete be executed e attending physician and d for use as the burial-trensit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	c		o (or as a conse							
d by th	by Physician	Part II. Other significant condition		death but not	rasulting in tha	underlying cause gi	ven in Part	l.		Decco use co		o the cause of death?
VICAL MECOFICS, P.O. Iclan: The law requires that the de certificate has been signed by the rector, page 2 should be detached	Completed by	Fleus							24a. Was ar perform	autopsy ned?	av	ere eutopsy findings ailable prior to mpletion of cause death?
	Be Com	25. Wes case referred to medical					26 Place	e of Deat	1 ☐ Ye		10	Yes 2□ No
OT VICE Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 25000	Hospitel: 15	Unnationt :	2 ER/Outpatie	ent 3 DOA Ot	hor:		me 5 Reside		nar (Specil	v)
ding Pr h. After th funera	Certification: T	27. Manner of Death  1 Netural 5 Pendin  2 Accident investig  3 Suicide 6 Could n	28a. Date (Mo	of Injury oth, Dey Yea	28b. Tima (Injury	of 28c. Inju Wo M 1			28d. Describe ho	w injury occu	rred	
E PRO		4 Homicide determi	ned 288. Plec	ding, etc. (Sp	ecify)	treet, factory, office	ana dati sa	4=1===	28f. Location (Str. City or Town	, Stete)		
To the Hospital within 24 hours To the Funeral I completely filled	Medical		Examiner: On the end ma			th occurred at the ti nvestigation, in my o	opinion, dee		red et the time, de		end due to	the cause(s)
T W D S		17-8	/wit		.0,	0	306		6	rec.	18,3	2000
10 DQ			MA-2710	V M	.0. 1	45 €		rre	1154.	5.	1:36	ion ME
Sta Registr		31. Date filed (Month, Dey, Year) DEC 2	2 2 2000 32.	Registrar's Si	ignature	b. Spo	als	,				

State of Maryland / Department of Health and Mental Hygiene 00 42726

MARCHAIR CHARLES TO STATE ALL PARTY NAME OF CONTROL ASSESSMENT AND ALL PARTY AND ALL P				Certi	ificate of	Death	R	leg. No.	0 4	2120
## Secretary Names of prior in whatenow, the whaten and numbers  ## Secretary Names of prior in whatenow, the whaten and numbers  ## Secretary Names of prior in whatenow, the whatenow of prior in the secretary of the secretary				2 E H 1	mE		Month	Day	Year	3. Time of Death  1:37 PM
S. Social Security Number  S. Social Security Nu		4a Facitity Name (If not institution, give	street and number)			0	ocation of Death	4c. County	of Death	
To State 100 County  Mid Carroll  To Street and Number  6109 Galkland Mills Road  107.20 Code  1107.20 Code  1107.20 Code  1108. Street and Number  6109 Galkland Mills Road  107.20 Code  1108. Street and Number  6109 Galkland Mills Road  107.20 Code  1108. Street and Number  6109 Galkland Mills Road  107. To Code  1108. Street and Number  6109 Galkland Mills Road  107. To Code  1108. Street and Number  6109 Galkland Mills Road  107. To Code  1108. Street and Number  6109 Galkland Mills Road  1108. To Code  1108. Street and Number  6109 Galkland Mills Road  1108. To Code  1108. Street and Number  1108. Street and Number  1108. Street and Number of Street Mills.  1108. Street and Number of Street Mills.  1108. Street and Number of Street Mills.  1108. Street and Number of Street Mills.  1108. Street and Number of Num	_	5. Social Security Number 6. Se 212-24-5724	x 7. Age (In yrs. i	last birthday)	If Under 1 Year	If Undar 24 Hrs.	8. Date of Birth	Year)	9. Birthola	ce (Stata or Foreig
Sementary (0-12)   Codego (1-tor 5+)   Codego (1-tor 5+)   Carpenter   State of Maryland Carpe	of show fied at	10a. State 10b. County				3/3/			100	d. tnside City Limite
To Note the Married and Married   Control of the	23e or 28e at be not		s Road		· ·				/hat Country	n
17, Faller's Name (Frist, Models, Last)   18. Mother's Name (Frist, Models, March Surname)   18. Mother's	if, or h	1 Never Married 2 Married	Armed Forces?  1 Ayas 2 No WW.  If Yes, Give				pecify Yes or No- pecify Yes or No- pecify Yes or No-	Black	k, White, et	C.
17. Father's Name (First, Micde, Last)   Roger D. Warrehime (spouse)   196. Mailing Address (Street and Number or Rural Route Number. Cay or Town. State. Zip Code)   196. Mailing Address (Street and Number or Rural Route Number. Cay or Town. State. Zip Code)   10.05 Warrehime (spouse)   196. Mailing Address (Street and Number or Rural Route Number. Cay or Town. State. Zip Code)   10.05 Warrehime (spouse)   10.05 Warrehim	then 'netur the Medical	(Specify only highast grad Elementary/Secondary (0-12)	a completed)			pation during most of won d)	king			
19a. Informants NameRelationship (Type, Prm)  Lois Warehime (spouse)  20b. Place of Disposition (Name of 100 Data)  20b. Data (Name of Data)  20b. Data (N	B v of							Maiden Sumam	e)	
10 Burlus 2	or trauma									
P.O. Box 195 Sykesville, Md 21784  234. Part Line the disease, or complicater's that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one that the street is accessed to each inc.  The modelac Cause (First Indiana List only the cause or each inc.)  The modelac Cause (First Indiana)  The mode	ury or oth	1 X Burial 2 ☐ Cremation 3 ☐ F	lemoval from State Lake	lace of Disposit emetery, crema > V1eW	tion (Name of tory or other pla Memoria.	(e) 12				
23a. Part I. Eiter the disease, or complications disease, or complications disease, or complications disease, or complications disease, or complications disease, or complications disease, or complications disease, or complications disease, or complications disease, or complications disease, or complications disease, or complications disease, or complications disease, or complications, disease, disease, or complications, disease, disease, or complications, disease, di	eny injudice									hapel
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  CCHRONIC REMA FAIWRE  DIABETES MELLINS  24a. Was an autopsy performed?  24b. Were autopsy finding available prior to completen of cause of death?  1   Yes 2   No 3   Probably Strünk  24a. Was an autopsy performed?  24b. Were autopsy finding available prior to completen of cause of death?  1   Yes 2   No 1	physician and street st	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or Due to (or Due to (or	MYO  as a conseque  ARY as a conseque	CAND ance of):  Ance of):	IAL 1	NFAR	CTION	>	
244. Was an autopsy performed?    245. Was case referred to medical examiner?   246. Place of Death (Check only one)	or use		ntributing to death but not resu	ulting in the und	erlying cause gi	ven in Part I.			ntribute to t	the cause of death
26. Place of Death (Check only one)  27. Manner of Death PSNatural 28a. Date of Injury Month, Day Year)  28b. Time of Injury Month, Day Year)  28c. tnjury at Work? 3 Suicide 4 Homicide  28c. tnjury at Work? 4 Homicide  28c. tnjury at Work? 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  28d. Describe how injury	2 should be	PIABETES	MELLIN	S			24a. Was a	an autopsy med?	avail	lable prior to pletion of cause
The state of the s	Con	05 W							10	Yes 2□ No
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ROBERT FINE. MD 540) OLD COURT ROAD RAND MUSTOUN MD 210	90	examiner? 1 Yes 22 No  27. Manner of Death  Watural 5 Pending	1 Unpatient 2 U	28b. Time of	28c. tnju	her: 4 Nursing H ny at nk?	ome 5 Resid	ence 6 □Othe		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ROBERT FINE. MD 540) OLD COURT POAD RAND MUSTOUN MD 210	d in by the	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he building, etc. (Specify	rna, farm, stree	t, factory, offica		28f. Location (S City or Tow	itreet and Numbe n, State)	er or Rural i	Routa Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ROBERT FINE. MD 540) OLD COURT ROAD RAND MUSTOWN MD 210	pietely fill		ner: On the basis of examinat	wledge, death o ion and/or inves	occurred at the ti stigation, in my	me, date and place opinion, death occu	, and due to the c rred at the time, c	ause(s) and ma late and placa, a	nner as star and due to t	ted. ha cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ROBERT FINE, MD 540) OLD COURT POAD PLAND AUSTOWN MD 210	E CO	29b. Signature and title of pertifier								
KOBERT FINE. MD 540, OLD COURT POAD KANDALISTOUN MD 21.		30. Namer and address of person who co		23a) (Type, Pr	int)	47587		DECEM	BEL	16, 2000
State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	CALL		22 Pagietrare Signal		DCOUP	T ROAD	KANE	AUSTO	UN I	mp 2113



State of Maryland / Department of Health and Mental Hygiene

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				Certifica	te of	Death		Re	g. No.		
	1. Decedent's Nama (First, Middle, La	ist)					2	Data of Death			3. Time of Death
Physician	Emma Cath	erine Wi	sherd					Month	Day 24	Year 2000	0200
/Medical	4a Facility Name (If not institution, give		oner a			4b. City, To		tion of Death	4c. County	_	
xaminer	Washington Count						stown			ingto	n
ral			(In yrs. last birtl	day) If Und	er 1 Year						
1		1□M 2□F		rs. Months		Hours	Min.	. Date of Birth (Month, Day,	Year)		aca (Stata or Foreign ry)
	215-36-5995 Usual Residence of Decedent	Λ	93		1	1	A	pr. 30,	1907	W . V.	irginia
	10a. State 10b. County		10c. City, Town	or Location						10	d. Inside City Limits
50	MD Washingt	on	Hager	stown							1 No 2 No
Director	10e. Street and Number			104.7	in Code			10	g. Citizen of \	Albed Count	-2
à					ip Code			10			ryr
Funeral	333 Mill Street				742				U.S.	-	
Ē	11. Marifal Status	12. Was Decedent En	var in U,S.	13. Was Dec	edent of I ecify Cub	Hispanic Or ean, Mexica	igin? (Speci n, Puerto Ri	fy Yas or No- can, etc.)		ce - Americe ck, White, e	
7	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🕅 No		1 ☐ Yes					Specifi	w. Whi	te
	3 ☑ Widowed 4 ☐ Divorced	Year or Datas:							opeom,		
ĺ	15. Decedent's E (Specify only highast gra	ducetion	16a. I	Decedent's Us Give kind of w	ual Occu	pation	st of working	1	6b. Kind of B	usiness/Ind	ustry
	Elementery/Secondery (0-12)	College (1-4or 5+		life. DO NOT	use retire	od)					
named the same	9	_		Homen	naker				own	home	
	17. Fathar's Nama (First, Middla, Last	)				18. Mother's Neme (First, Midd			laiden Surnan	ne)	
,	Alvey Albert Wor	thington				Mar	y Cat	herine	Womax		
	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Addre	ss (Stree	t and Numb	er or Rural	Route Number,	City or Town,	State, Zip	Code)
	Edwin L. Wisherd	/ son	120	010 Hol	iday	Circ	le	Smithsb	urg, M	D 21	783
	20a. Method of Disposition		20b. Place of	Disposition (N	ame of			Date 2	Oc. Location	City or Tov	wn, State
	Burial 2 Cramation 3			, crematory or			11.0	127/00	77		MD
	4 Donetion 5/□ Other (Speci		Rest Ha						Hager		
	21. Signature of Funeral Sendos Lice	NA						t Haven			-
	Valurtt"	1/ay		1601	Penn	isylva	nia A	ve. Ha	gersto	wn, M.	D 21742
	234 P. vt1. Enter the disease, or com	plications militias ed t	he death. Do n	ot enter tha mo	ode of dy	ing, such as	cardiac or	respiratory arre	st,	- 1	Approximata Interval Between
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	Immediata Cause (Final	1/	Prenm								-40
	disease or condition resulting in death)	4	Due to (or as a c		n.						2 00 N
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CABITILITIES	•	b	Nie to for on a o	2222222222222	h.					-	
	if any, leading to immediate		oue to (or as a co	Alsequence of	).						
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Medical	resulting in death) Last	D	ua to (or as a co	nsequance of	):						
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100										1	
Physician	Part II. Other significant conditions		_				l.	23b. Dld tol	bacco use co	entribute to	the cause of death?
	Anterio relati	is condio	vasal	a Dir	un	$\sim$		1 🗆 Ye	s 2 No	3 Prob	ebly 4 diknow
			-								
	Bitty Mall	they set	solul.	~ 6	nse	this		24a. Was ar		ava	re autopsy findings ilable prior to
	14								100	of c	npletion of cause leath?
-	Heart Frith	~						1 □ Ye	s 2DNo	10	Yes 2□ No
	25. Was cesa referred to medicel					20 01-	o of Dooth				
	examiner?	Hospital:			01 01	her:		Check only on			4
	1 ☐ Yes 2 ☐ No  27. Manner of Death	28e. Date of Injury			- CA	4014		e 5 🗆 Reside ld. Describe ho			"
	1 ☐Natural 5 ☐ Pending	(Month, Day	Year) 200. In	jury M	28c. Inju			a. Describe 110	anjary occur	.,64	
	2 Accident investigation 3 Suicide 6 Could not be		1			Yas 2		A Lacation (C)	and and M.	hos s = C	I Paula Mush
	4 Homicide determined		ry - At home, far (Specify)	m, street, facto	ry, office		28	If. Location (Str City or Town	, State)	ver or Hural	Routa Number,
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	one)	and manner state		or mivestigation	и, иг шу	ориноп, ове	Bill Occurred	at the time, de	ite and place,	and due to	(110 C0030(3)
2	29b. Signature and title of certifier			2	9c. Licen	se number			9d. Date signe		
	-0000	no		1,000	21	801.	9	1	Dec 2	4,2	000
	30. Name and address of person who	completed cause of de-	ath (Item 22a) (	Type Print)							
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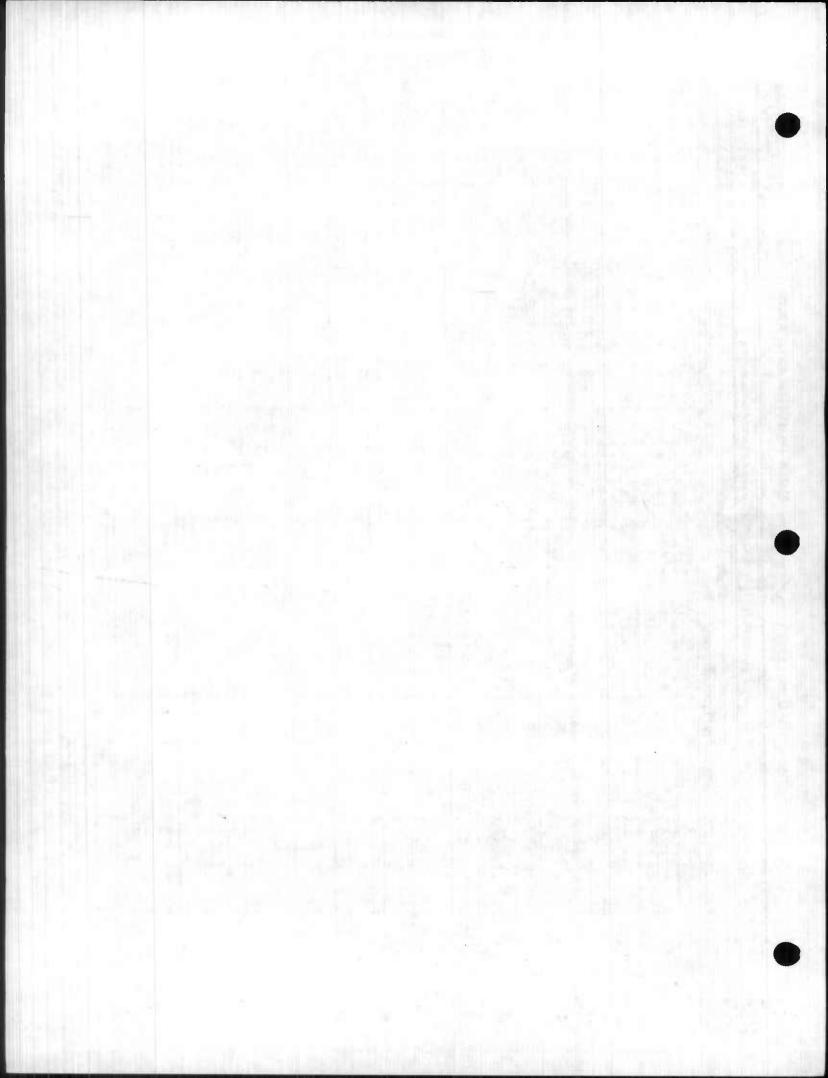
Amend Items 10d, 12,20b per Court Order, 9884-10/01/08dhb

Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day DECEMBER 17, **Physician** WACHTER 2000 HOWARD 5:10 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9103 Opossumtown Pike Frederick Frederick 8. Date of Birth (Month, Dey, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours 15 M 2□ F Yrs 90 Feb 28, 1910 Director 214-10-5661 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 23a or 28a-f show the Medical Examiner nast be nothed at 1 No Directo Frederick Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 9103 Opossumtown Pike 21702 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 IXYes 250 No. 1 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. or items 11. Marital Status filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: white Specify. by 3 Widowed 4 Divorced naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) Bookeeper/ Salesman 12 Sporting Goods Store other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) nit. Pages 1 and 2 should be surment of Health and Mental location; if them 27 is marked or Wachter Austin Lillie В. Holtz 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Beulah V. Wachter / wife 9103 Opossumtown Pike, Frederick, MD 21702 12/20/2000 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 Faith UnitedChurchofChrist12/17/00 Frederick, Maryland 21. Shinature of Funeral Service Licensee . Name and Address of Facility de la Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disaasa, or complications that caused the dear the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. Approximata Interval Between Onset and Death **Physician** fmmediate Cause (Final disaase or condition rasulting in daath) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examine med The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequenca of). Box 68760, Due to (or as a consequenca of) for Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I 23b. Did tobacco was contribute to the cause of death? P.O. funeral director, page 2 should be detached 1 Yss 2 No 3 Probably 4 Unknown 3 signed À Division of Vital Records, 24a. Was an autopsy performed? 24b. Were autopsy findings availabla prior to completion of cause of death? Be Completed this certificate has 1 Yes 20 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 212 No 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of To the Hospital or Attending P within 24 hours after death.
To the Funerel Director: After 1 Matural 5 Panding Injury investigation 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) deer ranc 32 Registrar's Signature 31. Data filed (Month, Dey, Year) State

DHMH 16 Rev 6/95

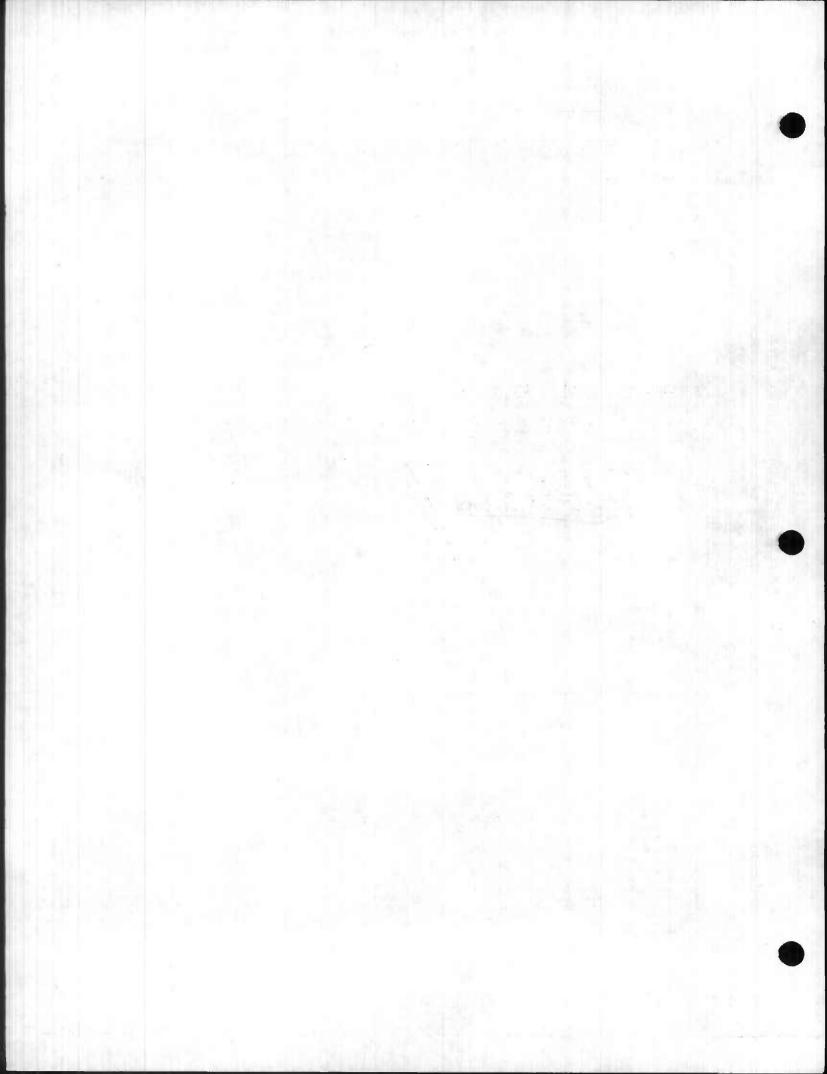
Registrar



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State of Maryland / Department of	f Health and Mental Hygiene

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poel	8 m			Ob. County		10c. C	ity, Town	or Location	n					1	0d. Inside City	Limits
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with th	3a or 28	Funeral Director	10e. Street and Number		urt			10	of. Zip Code 21702	2			Og. Citizen of V	Vhat Coun	try?	
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Maryland	- 3		19e. Informent's Neme										r, City or Town,		Code)	
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Baltimore,			20a. Method of Dispos 1 ☐ Burial 2 ☐ C 4 ☐ Donetion 5 [	remation 3 [		State	cemeter		(Neme of y or other place 11 Ceme		12	Dete /19/00	20c. Location -			nd
Balt	Department of important: if any injury or once.		21. Signature of Fund	al Service Lices	()	0.0	1						VERAL HO			<b>\1</b>
			23a. Pert1. Embr the shock, or heart in	disease or com	one cause on a	ach lin	1600					r respiretory an	FREDERI	LUK,	Approximate Interval Betwee Onset and De	een
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68760,	physician and s the buriel-transit	edicai Examiner	Sequentially list condit if any, leading to imme ceuse. Enter Underlyi Cause (Disease or inju- thet initiated events	ng Iry	c. h	13h 0	Loss	e s	terois	13					2	Ms
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W .	e atte	SICIS	Pert II. Other significa	nt conditions o	ontributing to de	ath but not re	sulting in	the underly	ying cause giv	ren in Pert I		23b. Did to	obacco use co	ntribute to	the cause of	death?
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	pege pege	000										1 D Y	es 28 No	1[	Yes 2 N	lo
Vita	entific actor,	D	25. Was case referred examiner?	to medical	Hospite!:				100		of Deeth	(Check only o	ne)			
Of	this o	0	1 ☐ Yes 2 ≅ No 27. Menner of Deeth		Hospitel: 1251			tpatient 3	LI DON		-		ence 8 Oth		y)	
Sion	oeth. or: After he funa	Sation	1 ☑Neturet 5	Pending investigation	n (Mont	h, Dey Year)		njury N	28c. Injui Wor	k? Yes 2□	0.1		ow anjury coool			
Divis	s after de N Directe ed in by t	Certific	3 ☐ Suicide 6 4 ☐ Homicide	6 Could not b determined	286. Piece	of Injury - At	home, fe	m, street, f	actory, office		1	28f. Location (5 City or Tow	itreet end Numb n, Stete)	er or Rure	I Route Numb	er,
Division of Vita	within 24 hours after deeth. To the Funerel Director: After this certificate has completaly filled in by the funarel director, page 2	edical certification:			niner: On the ba and mann	sls of examin										
Toth	withir comp		29b. Signeture and title	e of certifier	4				29c. Licens	e number		1	29d. Date signe	d (Month,	Dey, Year)	
			(1) res	1.5	H	Mo.	UP	ha	0	105	87		12/19	1/2	.000	
			29b. Signeture and title 30. Neme and address  GEAGE 31. Dete filed (Month, i	of person who	completed caus	e of deeth (Ite	em 23e) (	(Type, Print)	FAIR.	F	-RED	ERICH	HEHORA	- 17	701	
	State		31. Dete filed (Month, I	Dey, Year)	32. R	egistray's Sign	neture	1. 181	1		1-10	Chiles,	1100		,	
	Registra	r		DEC 1 S	2000	person	NAI	19	200	reks						

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Veer ROBERT T. WEIDMAN DEC 20 2000 12:10am 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. lest birthday) If Under 1 Year Months Days 5. Sociei Security Number 6. Sex Birthplece (State or Foreign Country) 1 M 2 F 202-16-6323 MAY 11 1924 PA Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥Yes 2 □ No MONTGOMERY POOLESVILLE 10e. Street end Number 10f. Zip Code 10a, Citizen of Whet Country? 10 SELBY COURT 20837 U.S.A. 12. Wes Decadent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Detes: WW II 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 🕱 No Specify: 3 Widowed 4 □ Divorcad WHITE 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) TOOL AND DIE MAKER BENDIX CORP. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme)

"natural", or items 23a death Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72: Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natt, any injury or other traumatic event, the Medical pine.

**Physician** 

/Medical

**Examiner** 

10e State

FRANCIS WEIDMAN

20a. Method of Disposition

Immediate Cause (Finei

19e. Informent's Neme/Relationship (Type, Print)

JEAN JANOSKO/DAUGHTER

1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify)

**Funeral** 

Director

28a-f show

0

Director

Funeral

by

Completed

traumatic event, the Medical Examiner must be notified at

Physician /Medicai Examiner

Box 68760.

P.O.

Records.

Division of Vital

Hospital or Attanding Physician:

The law requires that the death certificeta be

Examiner Physician/Medical þ Completed Be

physician end the burial-transit 950 been signed to should be date page 2 director. Certification: To After this funeral To the Hospital or Attanding within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fun

Preumonia disease or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or as e consequenca of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Disease 24e. Wes en eutopsy performed? 1 ☐ Yee 2 ☑ No 25. Wes case referred to medicel exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 27. Menney of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 TYes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner stated. 29a, Certifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer)

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Will WID 30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) 31. Dete filed (Month, Day Year) DEC 2 1 2000 6121 montrose

32. Registrar's Signeture

Rockville maryland 20852

70055258

ELIZABETH TICE

20837

Approximete Intervel Between Onset end Death

24 hrs

24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

1 ☐ Yes 2 ☐ No

December 20, 2000

20c. Location - City or Town, Stete

20838

12/22 ATHENS, PA

MD

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

10 SELBY CT., POOLESVILLE, MD

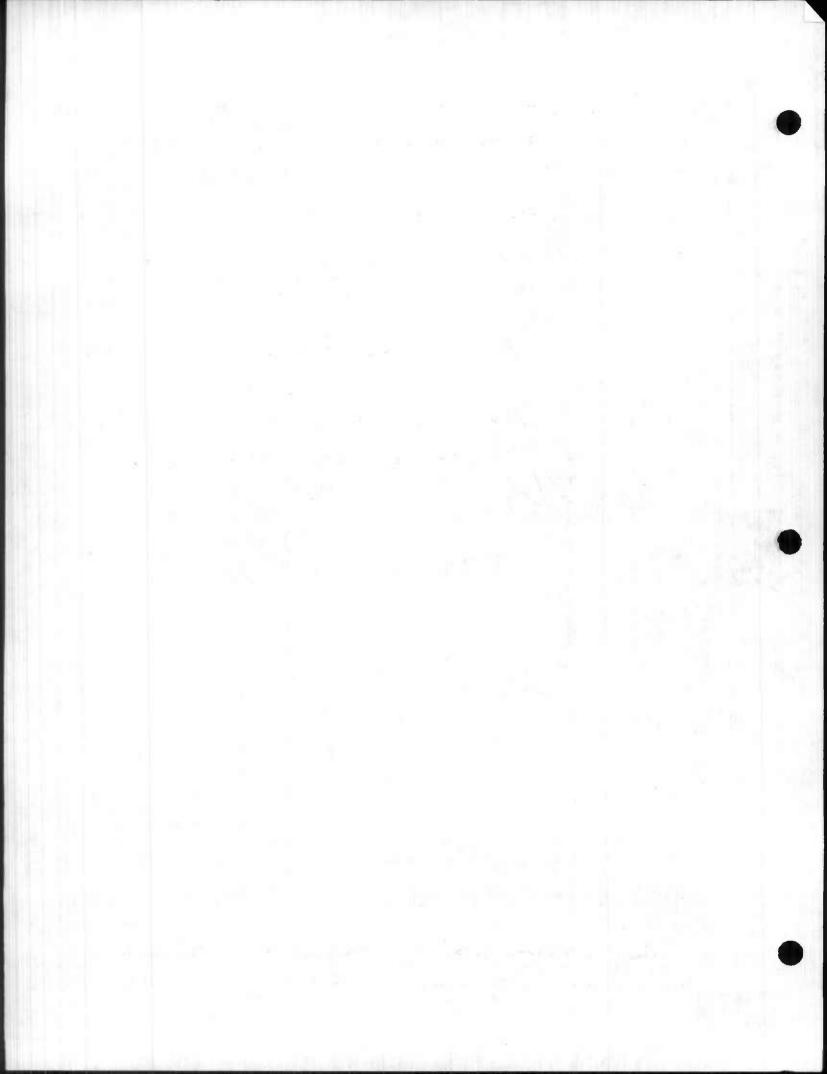
20b. Place of Disposition (Neme of cemetery, cremetory or other place)

TIOGA PT. CEMETERY

22. Name end Address of Fecility

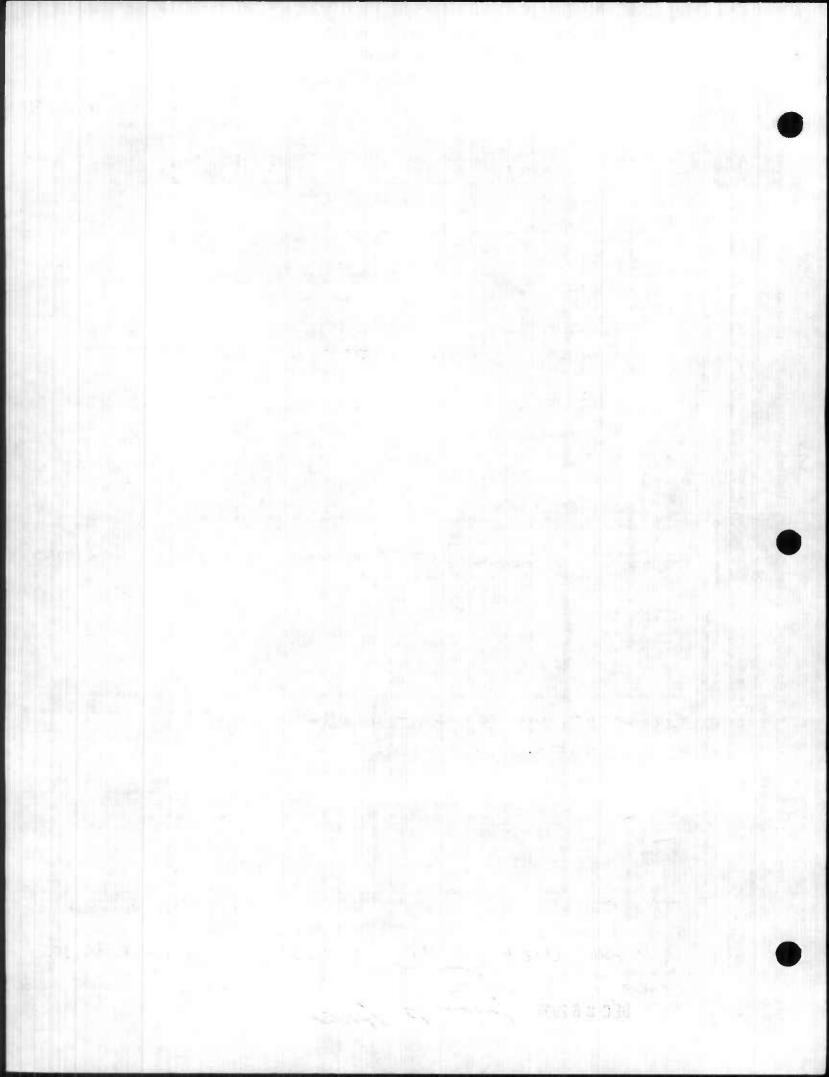
HILTON FUNERAL HOME BOX 86, BARNESVILLE,

State Registrar



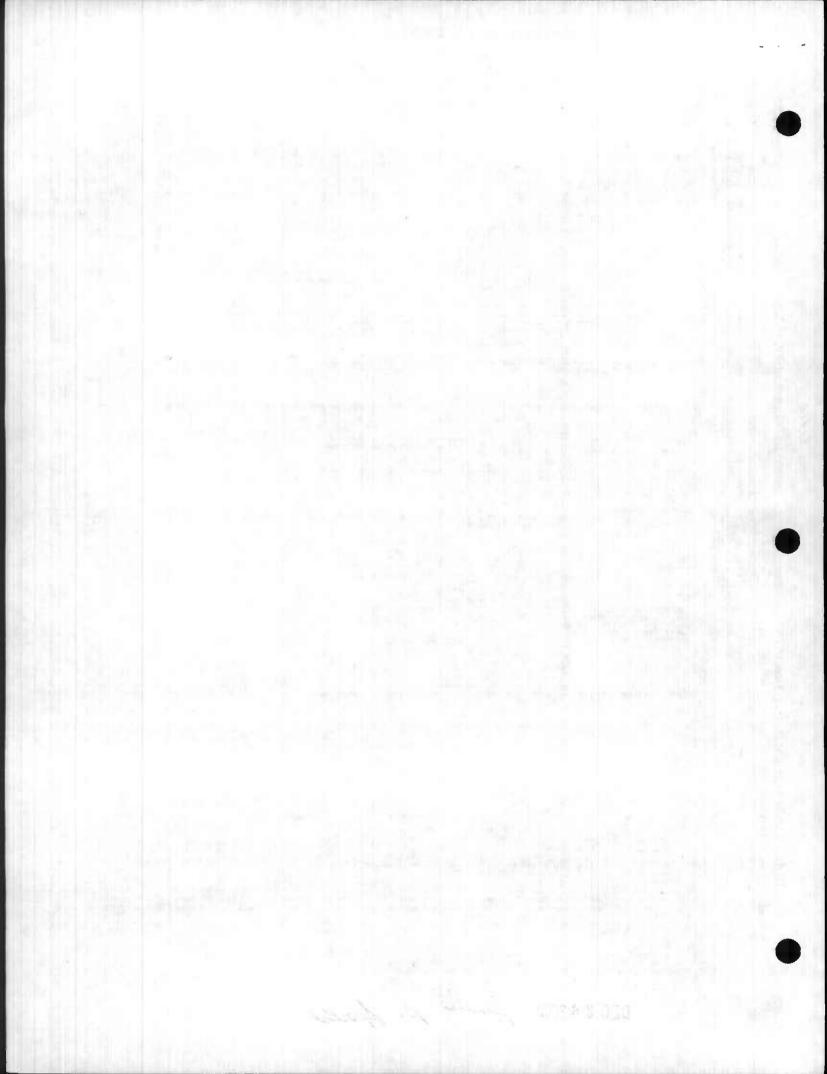
State of Maryland / Department of Health and Mental Hygiene 00 42731

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	/Medical Examiner	4a Fecility Nama (If not institut	4	um <i>ber)</i>			4	b. City, To	wn, or Lo	ocation of Deet	dc. Count	y of Death	
	LAMITIME			olia Tr	ail			Cam	brid	ae	Doro	cheste	er
1		5. Social Security Number	6. Sex	7. Aga (In yrs.		If Unde	r 1 Yaar	If Undar		_			placa (State or Foreign
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	vith the Ma t or 28a-f a be notified Director	10e. Street and Number				10f. Zij					10g. Citizen of	what Cou	ntry?
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Maryland	0 3 9 5	17. Fathar's Nama (First, Middle	e, Last)					18. Mothe	r's Name	a (First, Middle	, Maiden Surna	me)	
'lai	Menta Menta Mic en To B	Theodore E. Wa	alters					Bess	ie B	radford	3		
BT.	SPEE.	19a. Informant's Name/Relation	nship (Type, Print)		19b. Maili	ng Addras	s (Street	-			er, City or Town	n, State, Zi	p Code)
	27 te	Douglas Walter	e - con		503	Macmo	lia	Troil	Ca	mbri das	MD 2	21612	
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387	ficate be physicials the bu	rasulting in death) Last		Due to (d	or es e consec	quence of):							
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		30. Nama and addrass of person	n who completed as	ice of death the	m 23a) (Tuna	Print)	> (	00	- 1		COCE IV		100
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		31. Data filed (Menth Pay, Yea		Registrar's Sign	atura 1		2		1	MITTOR	1000	7 179	10.00
	State	DEC 2	5 2000	3300	9.	10	no M	200					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Veer **Physician** ISABELLE WROTEN 12:00pm SADTE 24 2000 December /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Mallard Bay Care Center Cambridge Dorchester If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Yeer Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys Months 10 M 25 F 92 214-07-8638 Director Aug. 10 1908 Maryland Usual Residence of Decedent 10c. City. Town or Location 10e Stete 10b. County 10d Inside City Limits TYPE 2 No MD Dorchester Cambridge Director 28a-f 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code ð must be 520 Glenburn Ave. 21613 U.S.A. 23a Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Yeer or Detes: 14. Raca - American Indien, 11. Meritel Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 à 1 Yes 2 No Specify: Specify: white by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) homemaker own home 10 18 Mother's Name (First Middle Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Pages 1 and 2 should be I nent of Health and Mental I unt: if Item 27 is merked or Abbott Insley Alverta Thomas 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 2039 Andrews Rd., Crapo MD 21626 Sandra M. Jackson-P.o.A. 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 三百 Department of Important: If any injury or Dorchester Memorial Park 12-26-00 Cambridge, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 21. Signeture of Funeral Service Licensee Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613 Greet & Approximete Intervel Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediete Ceuse (Final disease or condition resulting in deeth) /Medical Spiralion neumonia Examiner Due to (or es a consequence of): Examiner hysician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events that initiated events Due to (or es e consequence of) Box 68760. physician Physician/Medical thet initieted events resulting in death) Lest Due to (or es e consequenca of): 88 080 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 1 Yes 29 No 3 Probably 4 Unknown signed t þ Records, 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed page 2 certificete has 1 ☐ Yes 25 No 1 ☐ Yes 2 ☐ No of Vitai Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospitel: Certification: To 1 Yes 2 7 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deet 28b. Time of 28c. Injury et Work? After Division or Attending 5 Pending investigation 1 Daturel death. 1 Yes 2 No 2 Accident 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29e. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number 12.24.00 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 400 MARYLAND AVE. CAMBRIDGE MD. 21613 ANN R- WILKE, MD

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2000 DECEMBER 9:40 AM Barbara Ann Wood /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner St. Mary's St. Mary's Hospital Leonardtown 8. Date of Birth (Month, Day, Year May 27, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplaca (Stete or Foreign Country)
Maryland 6. Sex 7. Age (In vrs. last birthdev) **Funeral** Months Days Hours 1 M 2 X F Yrs. 1937 217-34-3617 Director 63 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Mechanicsville 28a-f St. Mary's Maryland 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 items 23s U.S.A. 41740 New Market Turner Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c.
Department of Health and Mental Hygiena.
Important: If Item 27 Ie marked other than "natural", or iten any Injury or other traumatic access 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Detes: 1 Yes 2 No Specify. Specify: þ White 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Own Home 12th Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Indianna Florist Mason Joseph Kenneth Elliott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 103 Pine Street, Chestertown, Maryland 21620 Charlene Y. Fowler (Daughter) 20b. Pieca of Disposition (Neme of 20c. Location - City or Town, Stete 20e. Method of Disposition Date cemetery, cremetory or other place) 1 Buriel 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Gardens 12/11/00 Lexington Park, Maryland 21. Signetyre of Funeral Service Licenses 22. Name end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. lardenes P.O. Box 270, Leonardtown, Maryland 20650 eller 23a. Pert1. Enter the disease, or complications that ceused life swith. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each lin **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) 6 mms BRMJ Turnor Examiner Due to (or es a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequença of) Physician/Medical Due to (or es a consequence of) signed by the atte 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? has 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No this certificate funerel director. 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2√ No Impatient 2 ER/Outpetient 3 DOA 27. Megner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Attending 1/2 Neturei 5 Pending 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident investigetion 6 Could not be determined 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. Medical 29e. Certifier completaly (Check only one)

State Registra

21215-0020

Maryland

Baltimore,

MARVI

ANN

BARBARA

Division

KHALID HUSAIN M.D. Dete filed (Month, Dey, Year)

DEC 11 2000

29b. Signeture end title of certifier

32. Registrer's Signeture

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

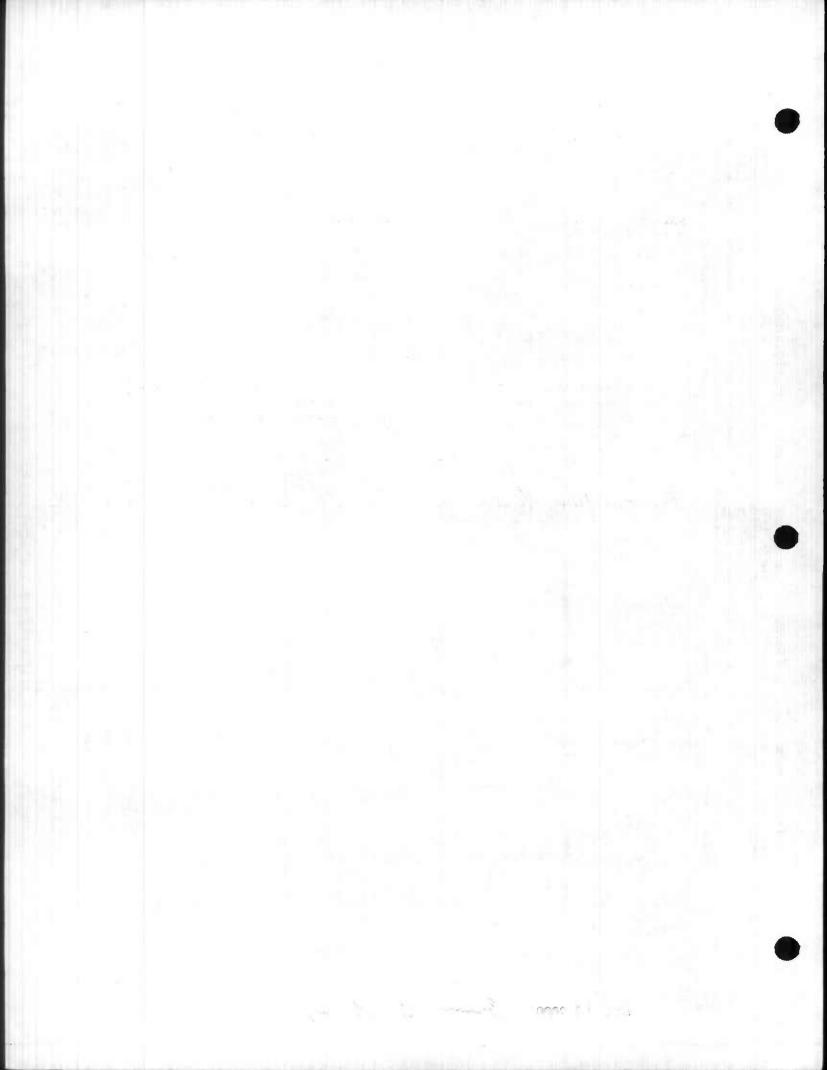
29c. License number

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BRENTON MEDICAL GROUP 22576 MCARTHUR BLVD. CALIF, MD. 20619

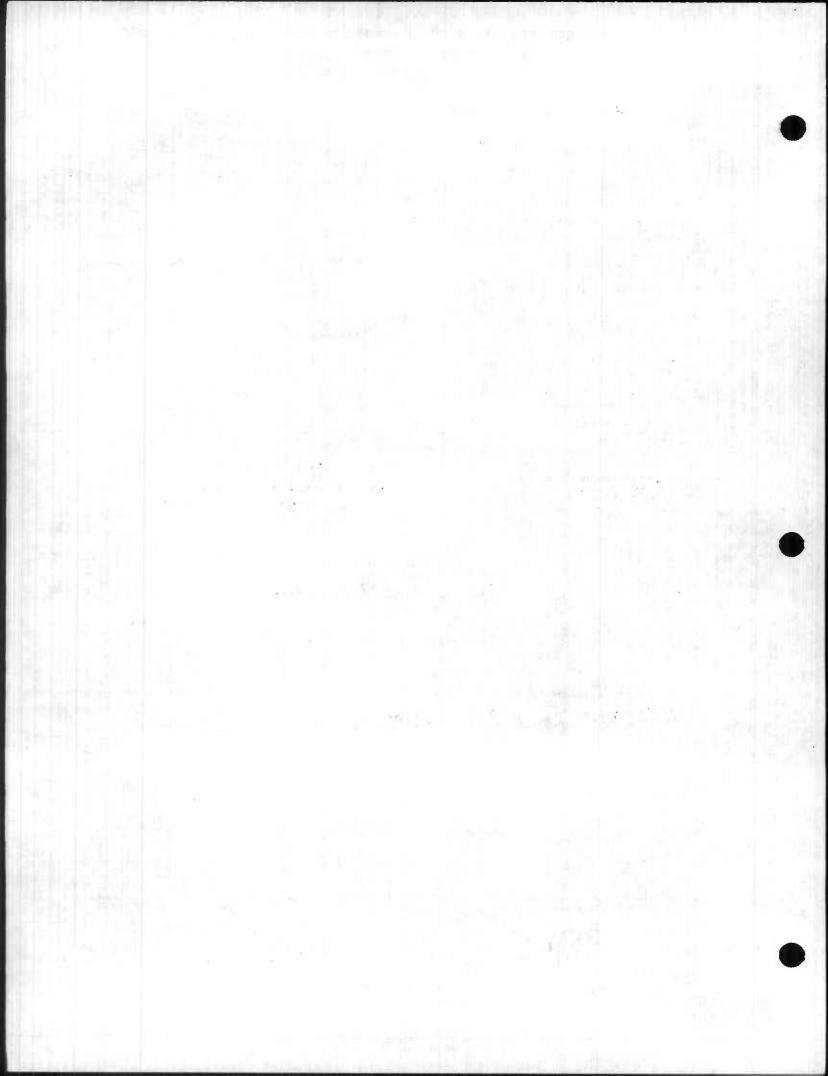
29d. Date signed (Month, Day, Year)

12.8.W.



				Cer	rtment of tificate o	f Death		1	Reg. No.	4	2734
ysician	Decedent's Name (First, Middle	e, Last)					2	. Date of Dec Month	ath Day	Year	3. Time of Death
Medical	Gordon	Clark Wi	11iam	S	1 1		7	ecembe			0450
aminer	4e Facility Neme (If not institution	, give street and number	er)			4b. City, To	own, or Local	tion of Death	4c. County	of Death	
	The Memoria					Eas	ton		Talk		HE I DEAL
neral	5. Social Security Number	6. Sex 7 12 M 2 □ F	Age (In yrs. I		If Under 1 Ye Months Day			Date of Birt (Month, De		9. Birthpla	ace (State or Foreign ry)
ctor	124-22-0369	123.		70 Yrs.			Oc	ctober 2	2, 1930	Penns	sylvania
Director	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10	d. Inside City Limits
tor	Maryland Caro	line	Ri	idgely							1 ☐ Yes 2 ☑ No
Directo	10a. Street and Number	20 FIRST =			10f. Zip Code	е	1 13		10g. Citizen of V	Vhat Count	ry?
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Funeral	11. Marital Status	12. Was Decede		S. 13. V	Ves Dacedent o	of Hispanic Or	rigin? (Specif	v Yes or No	- 14. Rac	e - Americe	n Indian,
	1 Never Married 2 Married	Armed Force led 1 Tyes 2 [ If Yes, Give	S7 ∃No 194	19- "	Yes, specify C			can, etc.)	1000	k, White, e	
by	3 Widowed 4 Divorced	If Yes, Give Yeer or Deter	s: 195	52	☐ Yes 2☐x	No Specify	r:		Specify	casia	n
8	15. Decedent			16a. Deced	ent's Usual Oc	cupation	. 4 . 4		16b. Kind of Bu		
Completed	(Specify only highes Elementery/Secondery (0-12)	College (1-4c	or 5+)	life. (	kind of work do OO NOT use ref	ne auring mo tired)	si or working				
EO	12 HS Grad.	00390 (1.40		Autor	nobile s	Servic	e		Autom	otive	
0	17. Father's Name (First, Middle,	Last)				18. Moth	er's Name (/	First, Middle,	Maiden Sumam	10)	
0	Frederick 1	Rex William	s			Kati	herine	Bulle	ock		
	19a. informent's Neme/Reletions	hip (Type, Print)		19b. Mailin	g Address (Stre	eet and Numb	per or Rural F	Route Number	er, City or Town,	State, Zip	Code)
	Dora R. William	ns Wif	e	11664	Reeds	Circl	e, Rid	gely,	Marylan	d 216	60
	20a. Method of Disposition		20b. P		sition (Name of natory or other)			Date	20c. Location -		
	1 Buriel 2 XCremetion 4 Donation 5 Other (St		16		Cremato		112	/10/00	Dover,	Dolo	
-	21. Signature of Funeral Service				. Name end Ad			/ 19/0	Dover,	Dela	iwaie
37	City on ple 1	/ / /hore			oore Fu						
	23a. Pet1. Enter the disease, or	- 1 //our	and the and a sta								and 21629 Approximate
ы	shock, or heart failure. List	only one cause on each	ine.	. Do not ente	er the mode or o	dying, such e	s cardiac or i	espiratory a	rrest,	1	Intervel Between Onset end Death
	In a dista Cours (Final		0							1	,
	Immediate Cause (Final disease or condition resulting in death)	s	rne	umm	ia					11	WEEK
-		./	Due to (or	as a conseq	uence of):	1	1.			1	math
nin		b	cute	Mono	aftic	Leu	temi	2		1	mmth
Examiner	Sequentially list conditions, if any, leading to immediate	\$5,75,47	Due to (or	es a conseq	uence of):						
	Cause (Disease or injury	с								i	
dic	that initiated events resulting in death) Last	15 01/19	Due to (or	as e consequ	uence of):					1	
/Me		d									
by Physician/Medical	Part il. Other algnificant conditio	ne contributing to death	but not resu	ilting in the ur	deriving cause	given in Part	1.	23b. Dld	tobacco use co	ntribute to	the cause of death
hys	ma 4 1 1	1				Section			Yes 25 No	-	ably 4 ☐ Unknow
Y P	Metastatic ,	Cenal Cu	L Ca	rano	ma.						,
								24a. Wes	en eutopsy	24b. We	re autopsy findings ilable prior to
Completed								pend	ormed?	con	npletion of ceuse leath?
du.								15	Yes 2 No		
= 1	or W							10		11	Yes 2□ No
	25. Was case referred to medicei	Hospital:				Other:	ce of Deeth (			45	
Be	examiner?	1 1 Inpi		ER/Outpatien 28b. Time of	T 3LI DUA	4 L I N			dence 6 Oth how injury occur		)
To Be	examiner? 1 Yes 2 No	28a Date of the	and y	Injury		njuryat Work? I∐Yes 2 [		d. Describe	mjury occur		
To Be	examiner? 1   Yes 2   No  27. Menner of Death 1   Netural 5   Pendin		Day Year)		141						
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edical Certification: To Be	examiner?  1  Yes 2 No  27. Menner of Death  1  Acident  2  Accident  3  Suicide  4  Homicide  29a. Certifier (Check only one)	g (Month, in the best of the last of the last of the last of the basis	Injury - At ho etc. (Specify st of my know	Wiedge, deeth	eet, factory, offi	e time, date a ny opinion, de	28 and place, and	City or To	cause(s) end madate and place,	anner as sta	ated. the ceuse(s)

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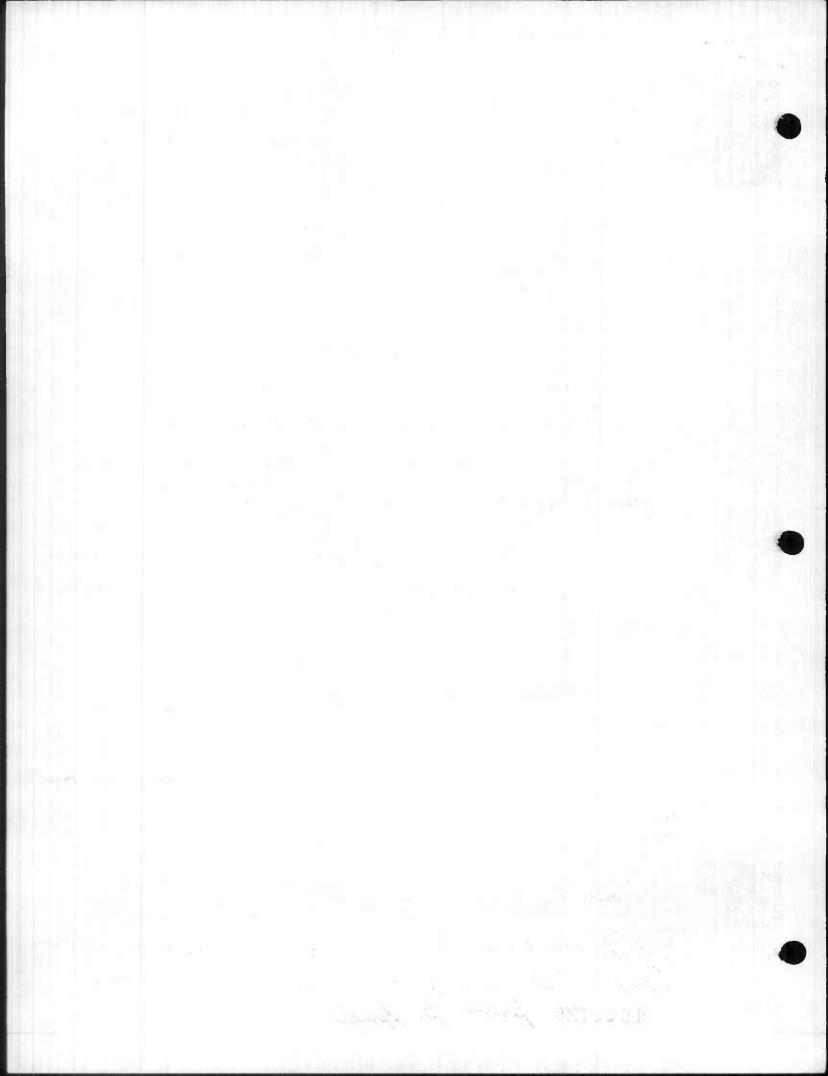


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State of Maryland / Department of Health and Mental Hygiene 0 4 2 7 3 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Roland Copeland Woolford

	/Medi Examii		4a. Facility Name (If n			umber)				4b. City, Tow		tion of Deal	th 4c. Count	ty of Death	-0/	3)
			1248 Hud			7 4-2 //	land bidteday	If Under		Cambri	- 10	D. ( . ( D)		cheste		
	Funeral Director		5. Social Security Nun 220–26–296 Usual Residence of D	59	M 2□F	7. Age (In yrs. 74	Yrs.		Days	If Under 2 Hours	Min.	Date of Bi (Month, Di LY 29	rth ay, <i>Year)</i> 1926	9. Birthp Coun Maryl	lace (Sta try) and	te or Foreign
	Marylend a-f ehow	tor		Ob. County  Dorches	ter		y, Town or Lo							1		e City Limits
	3s or 28s	al Director	10e. Street and Numb		d			10f. Zip		1613			10g. Citizen of U.S.A		ntry?	
020	72 hours after death with the Maryland naturel', or items 23s or 28s-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 3 Wildowed 4		Armed F	2 □ No ive		Was Decedif Yes, special		lispanic Orig an, Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No can, etc.)		14. Raca - American Indien, Bleck, White, etc. Specify: white		
121	within iene. r than	Completed	(Specify Elementary/Second	5. Decedent's Econly highest gra ary (0-12)	de completed)		(Give	tent's Usua kind of wor DO NOT us ICK dr	k done e retired	during most d)	of working		16b. Kind of Business/Industry  oil company			
yland	should be filed and Mentel Hygis marked other umatic event, II	To Be C	17. Father's Name (Fi										, Maiden Sume Ceaves	me)		
Mar	~ ~ ~ ~		19a. Informant's Nam										per, City or Town	n, State, Zip	Code)	
re, l	Healt Healt		Daniel L. 20a. Method of Dispos	sition		20b. P	RD 9	sition (Nam	e of	Mills	sboro,	DE Date	19960 20c. Location	- City or To	wn, State	÷
E .	timor  I. Pages tment of I tant: if ite		1 № Burlal 2 🗆 6 4 🗆 Donation 5			State	land V				rv12-	-22 H	Jurlock,	Mary	land	
Baltimore,	permit. Pege Department of Important: if eny injury or sncs.		21. Signature of Fune	ral Service Ligar	500		22	. Name and	d Addre	ss of Fecility	Thor	nas Fi	neral H			
P.O. Box 68760,	thet bed to dete	by Physician/Medicai Examiner	23a. Part I/Enter the shock, or heart f Immediate Cause (Fidisease or condition resulting in death)  Sequentially list cond if eny, leeding to imm cause. Enter Underly Cause (Disease or Injudit infliated events resulting in death) Last	nal itions, ediate ing ury	a. <i>Cr</i> b. <i>Cb</i> c	Due to (or	Azn or es e consec Az fe r es a consec or as e consec	uence of):	en en	uA se		23b. Did	tobacco use co		Onset e	Between nd Death
of Vital Records, P.O. Box 6 Physician: The law requires thet the deeth certific	The law requir ete hes been s page 2 should	Completed b									_	perf	s en autopsy ormed?	ave cor of c	ere autop ailable pr mpletion death?	of cause
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o	this eldi	-T	Yes 2 No 27. Manner of Death		28a. Date		ER/Outpetier 28b. Time of			4 LI NUI	-		Idenca 6 Ot		y)	
	tanding leeth. or: After the fune	Certification:	1 ■ Natural 2 ■ Accident	5 Pending investigation	(Mon	nth, Dey Year)	Injury	М		k? Yes 2□N	10		how injury occu			
DIV	tal or Attandi s after deeth al Director: A ed in by the f	Certif	4 ☐ Homicide	determined	288. Plac	a of Injury - At ho ing, etc. <i>(Specif</i> )	ome, farm, str /}	eet, factory,	, office		28	City or To	(Street and Num wn, State)	i <i>ber</i> o <i>r</i> Hura	i Houte r	Vum <i>ber</i> ,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one)	Certifying Ph ☐ Medical Exam	iner: On the b	best of my know asis of examinat oner stated.	wledge, death tion and/or Inv	occurred a restigation,	t the tir In my o	ne, date and pinion, death	i placa, and h occurred	d due to the at the time	cause(s) and m date and place	nanner as st , and due to	tated.	se(s)
	with To t	M	29b. Signature and tit	e of certifier	Un			1		e number	8		29d. Date sign			
	Sta	te	30. Name and address 31. Date filed (Month,	Day, Year)	Eller	se of death (Item	300-1	Print)	TG	AU	e f	korlo	Dec 1	-164	3	
	Registr		DEC	2 2 2000	324	war	19.	Loon	1							

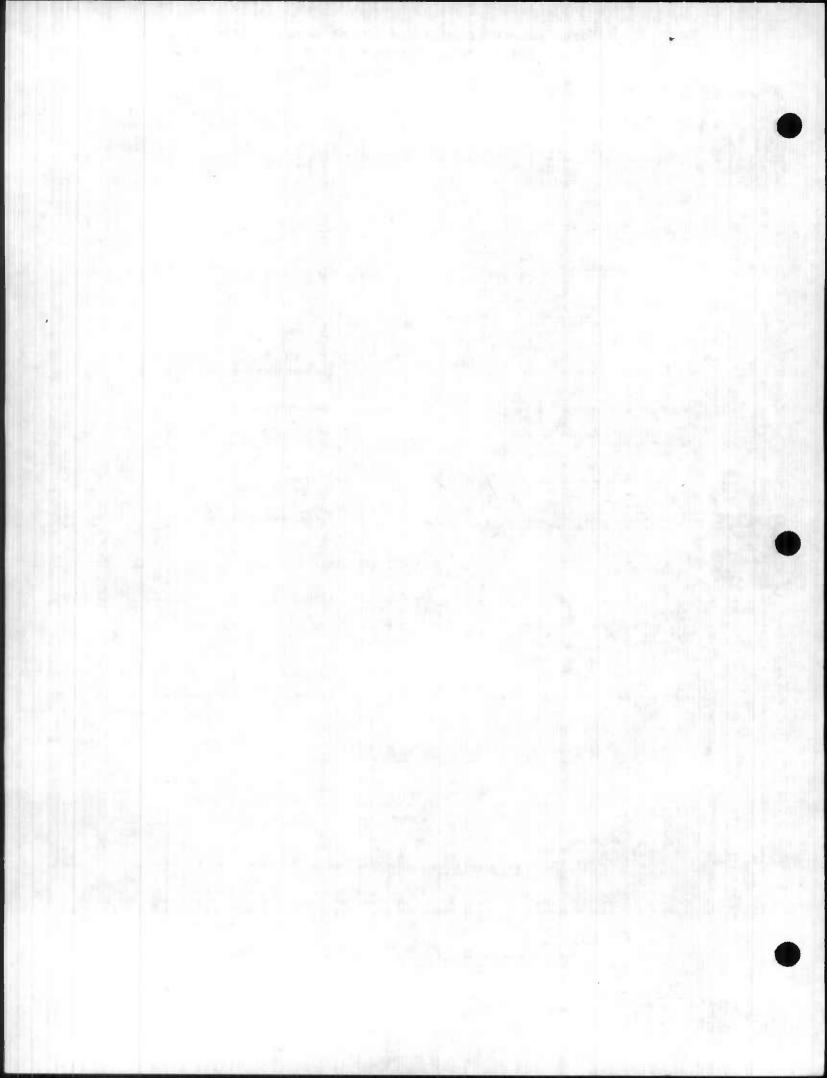
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State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death		Reg. No.	74100							
Dhunisia.	Decedent's Name (First, Middle, Last)	2. Date of De Month	ath Day	3. Time of Death Year							
Physician /Medical	Bernard J. Zeak	Decemb		000 3:00 P.M.							
Examiner		or Location of Deat	4c. County	of Death							
	Citizens Nursing Home Frede	rick	Fre	derick							
Funeral	5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthdey) If Under 1 Year 1 funder 24	Hrs. 8. Date of Bir Min. (Month, De	th	Birthplace (State or Foreign Country)							
Director	716-10-4596 1\(\frac{1}{2}\) M 2\(\sigma\) F 94 Yrs. Months Days Hours 1	June 16		Pennsylvania							
	Usual Residence of Decedent	pane 10	, 1,000	1 Child   1 Valle							
ylen Maria	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits							
Mar Mar	Maryland Frederick Frederick			1  Yas 2 □ No							
vith the Ma	10s. Street and Number 10f. Zip Code		10g. Citizen of W	/hat Country?							
1 N N N N N N N N N N N N N N N N N N N			United S	tatos							
15-0020 72 hours after death with the Maryland fretural; or flerna 23a or 28a-f show ideal Examiner must be notified at least of the Figures in Director	2101 Rocky Gorge Court 21702  11. Marital Status 12. Was Decedent Evar in U.S. 13. Was Decedent of Hispanic Origin			- Amarican Indian,							
Herr d	11. Marital Status  12. Was Decedent Evar in U,S. Armed Forces?  1 □ Never Married 2 ☑ Married  12. Was Decedent of Hispanic Origin If Yas, specify Cuban, Mexican, P	uarto Rican, atc.)	Blac	k, White, etc.							
O20 urs at			Specify	White							
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nd 212 e filed withi al Hygiene. other than vent, the		Nama (First, Middle									
Maryland 21215-0020 d 2 should be filed within 72 hours aff th and Mental Hygiene. T'le marked other than "natural", or traumatic event, the Medical Exam To Re Completed by E											
Via Menida				lelland							
Aan and is me	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of										
and and and a national nationa	Barbara Hill / daughter 2101 Rocky Gorge Cou	1									
or of H	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Placa of Disposition (Neme of cematery, cremetory or other place)	Date	20c. Location -	City or Town, Stata							
Peg Peg Int: h	4 Donation 5 Other (Specify) ResthavenMemorialGardens	12/21/0	Freder	ick, Maryland							
Baltimore, Maryland Spemit. Peges 1 and 2 should be illed Department of Health and Mental thy important: if item 27 is marked other any injury or other traumatic event, once.	21 Someture of Funeral Service Licensee  22. Name and Address of Facility Stauffer Funeral Homes, P.A.										
Ball Departiment any tr				ND 01700							
	23a. Part 1. Enter the disease, or complications that caused the death Double and the mode of dying, such as ca	rdiac or respiratory a	rest.	MD 21702 Approximate							
	shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death							
Physician /Medical	Immediate Ceuse (Final			1. 1- 1							
Examiner	disease or condition resulting in death) a.			week							
	Due to (or as a consequence of):										
De its	b. Dementia			years							
axecuted and faltransk	Sequentially list conditions, Due to (or as a consequence of): if any, leeding to immediate										
60, be a											
68760, ifficate be assouted g physician and as the burial-transit	that initiated events  Dua to (or as a consequence of):  resulting in death) Last										
5 04											
0 65 6											
O. BC he death the atter the atter ched for u	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did	tobacco uss con	tributs to the cause of death?							
P.O. at the at the day the etache		1 🗆	Y88 200 No	3 Probably 4 Unknown							
es that es that igned by determined by Dy Dy Dy Dy Dy Dy Dy Dy Dy Dy Dy Dy Dy		_									
cords v requires been sign should be			an autopsy	24b. Were eutopsy findings available prior to							
Records, le law requires to has been signinge 2 should be		_		completion of cause of death?							
The law requirements that has been single based and Completed		10	Yes ZENo	1 ☐ Yes 2 ☐ No							
Vital I		Death (Check only	•								
	examiner?			(0							
0 5 53	1 Yes 2 No Inspired 2 ER/Outpatient 3 DOA 4 Thersi 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ng Home 5 ☐ Res	how injury occur								
dlng h. After funer	27. Manner of Death  1 Natural  1 Natural  1 Natural  1 Natural  1 Yes 2 No										
Attending r death.	2 Accident investigation M 1 Yes 2 No. 3 Suicide 6 Could not be		Ctroot and Alumb	and Dural Davids Alumbar							
	4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or To	wn, Stete)	er or Rurel Routa Number,							
O series											
n 24 hours n 24 hours se Funeral pleiely filled	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and p  Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth										
T T T T T T T T T T T T T T T T T T T	29b. Signature and fittle of cartilles 29c, License number	-[-[	29d. Date signe	d (Month, Day, Year)							
	100 100 104 15	26	12/10	100							
	30. Name and address of peutograms completed cause of deeth (Item 23a) (Type, Print)			MARRYLAN							
	WILLIAM H. JCHWSCH, MID 177 1HON	145 JEH	NEWID	P. FREDERICA							
State	31. Date lifed (Month, Day, Year) 32. Registrar's Signature										
Registrar	DEC 2 1 2000										
				***							

DHMH 16 Rev 6/9



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 4 2 7 3 7 Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death ZAVISTOVICH **Physician** 7:45 pm KUSSELL 20 D+ C 2000 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Hospital Fort Washington Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** 1√2 M 2□ F 152-24-4491 Yrs. Director 1,1928 Wilno, Poland Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits from 27 is marked other than "natural", or items 23a or 28a-f abov other traumatic event, the Medical Examiner must be notified at Maryland Prince George's Fort Washington 1 ☐ Yea 2 ◯ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? with 20744 USA 724 Tantallon Drive West permit. Pages 1 and 2 should be filed within 72 hours efter death 1 Department of Health and Manial Hygiene. Important: if frem 27 is marked other than "natural", or items 23s any injury or other traumatic avants. Funeral 12. Was Decedent Ever In U.S. Amed Forces? 1/D/yes 2 □ No Korean If Yes, Give War Year or Dates: 14. Race - American Indien. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Black, White, etc. 1 Never Married Married Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) Language Specialist Federal Government 18. Mother's Name (First, Middle, Malden Surneme) 17. Father's Name (First, Middle, Last) Mikhail Alexander Zavistovich Antonina Ivanovna Verzhbitski 19b. Mailing Addrass (Straat end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Iraida Zavistovich/Wife Same as item 10 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Rock Creek Cemetery 12/26/2000 Washington, D.C. 4 Donetion /5 ☐ Other (Specify) George P. Kalas Funeral Home, P.A. Juneral Service Licensia 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 UM 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, abock, or heart failure. List only ona cause/or each line. Approximate tntarval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) PULMORARY ATPIRATION PREUMONIA a. MASSIVA Examiner Due to (or as a consequence of): Examiner MY UNARDIAL TN ARA- TION MINUTAS Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Due to (or as a consequence of): Physician/Medical 8 Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown P 24b. Were autopsy findings aveilable prior to 24e. Was an autopsy performed? Completed completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No to 27. Mannar of Death 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: 1 BNatural 5 Pending il or Attendin i after death. I Director: All 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify) 4 Homlcida Hospital 24 hours o 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and mennar stated. edicai 29a. Certifier (Check only one) To the 1 To the 1 To the 1 Complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) eg boll DC 7348

11701 LIVINGS FON Rd. Et. WASH. MX 20744

Registrar

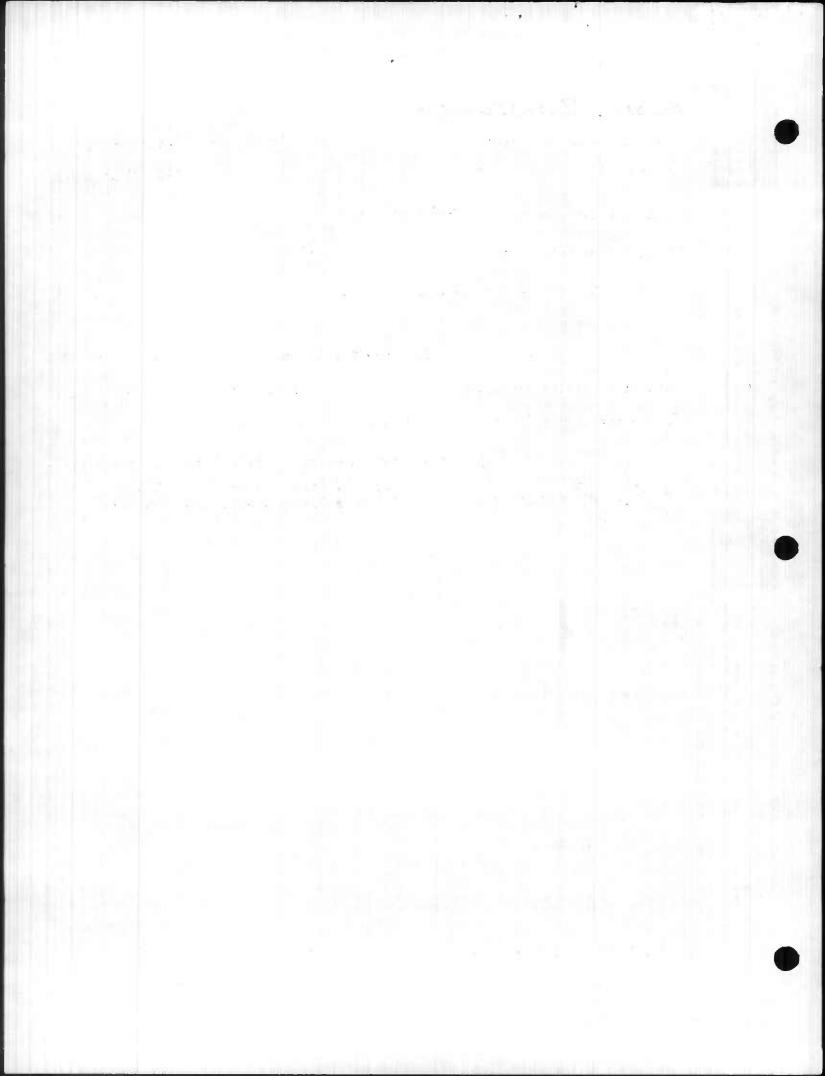
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30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

32. Ràgistar's Signature

NEDZBALA

31. Date filed (Month, Day, Year)
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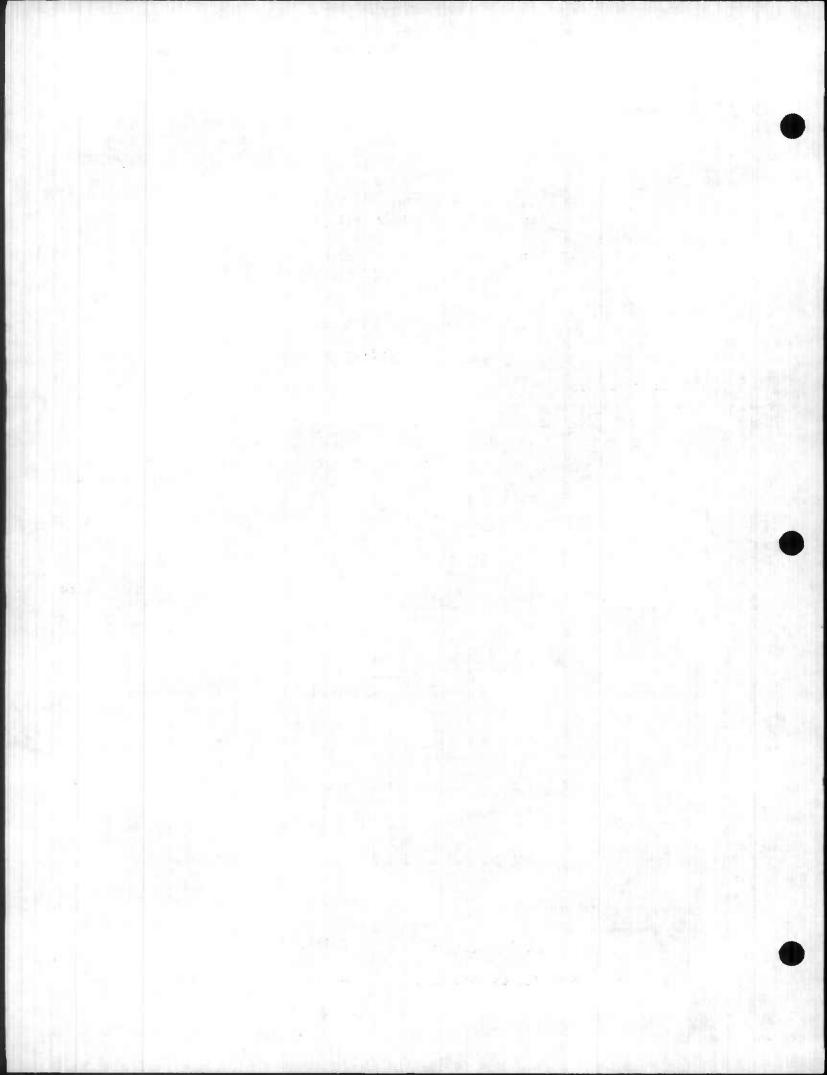


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/Medica	al .	Geneva								12/9/	00		7:00	P.M.
Examine	er	4a Facility Neme (	If not institution, give	street end num	ber)				4b. City, Town, or I		4c. County	of Deeth		
			e Center						Silver S		Montg	omery	7	
Funeral Director		5. Social Security N 579-07-9 Usuel Residence of	625	ox □M 2 <b>삼</b> F	7. Age (In yrs. 99	lest birthday) Yrs.	If Unde Months	Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day 8/14/	7 Year) 1 901	Coun	lece (State try) tanbu	
the Maryland 28a-f show notified at		10a. Stete	10b. County		10c. Ci	ty, Town or Lo					919	1	0d. Inside C	
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vithin 72 ne.	Completed by	(Specification) (Specification	15. Decedent's Edicify only highest grad		4or 5+)	16a. Decedent's Usuel Occupa (Give kind of work done di iife. DO NOT use retired) Tailor			during most of wor	16b. Kind of Business/Industry  Private				
and 212 be filed with ital Hygiene. d other than svent, fix	ŭ		(First, Middle, Last)			1	4110		18. Mother's Nar	ne (First, Middle,				
aryland 2 should be filed v and Menial Hygie s marked other s urmatic avent, in	To Be		ce Brown							Laura Fu				
S should and M		19e. Informent's N	eme/Reletionship (7	ype, Print)	3 10 1	19b. Meilir	ng Addres	s (Stree	end Number or Ru	ural Route Numbe	r, City or Town,	Stete, Zip	Code)	123
Mg 2nd 2 27 le r treu														
Baltimore, Maryle permit. Pages 1 and 2 should Department of Health and Merimportant: if item 27 is marke any Injury or other treumatic pages.		Lonnie Brown/ Brother 5302 14th Street, N.W. Washington, D  20a. Method of Disposition  1  Burial 2 Cremetion 3 Remove from Stete 4 Donetion 5 Other (Specify)  20b. Place of Disposition (Neme of cemetery, cremetory or other place) Lincoln Cemetery  12/15/00 Suitland										- City or To	wn, Stete	
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6876( ificate be g physicia as the burn	edical	Cause (Disease or that initieted event resulting in death)	injury s Last	cDue to (or es a consequence of):										
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Division To the Hospital or Attending within 24 hours siter deeth. To the Funeral Director: After completely filled in by the funeral	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Plece o	of Injury - At h g, etc. (Special	ome, ferm, str	eet, facto	ry, office		28f. Location (Street and Number or Rurel Route Number City or Town, State)				n <i>ber</i> ,
To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier (Check only one)	1⊠ Certifying Phy 2☐ Medical Exam		is of examine									s)
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6		· A	rend	eller	el	QM	0	D382	262		Jan 6	,20	01	
CAS,		Dr. Anur	ess of person who c ita Mendh	ompleted cause iratta	2401 R	n 23a) (Type, esearc	h Bly	7d. S	Suite 340	Rockvil	le, MD.	208	50	
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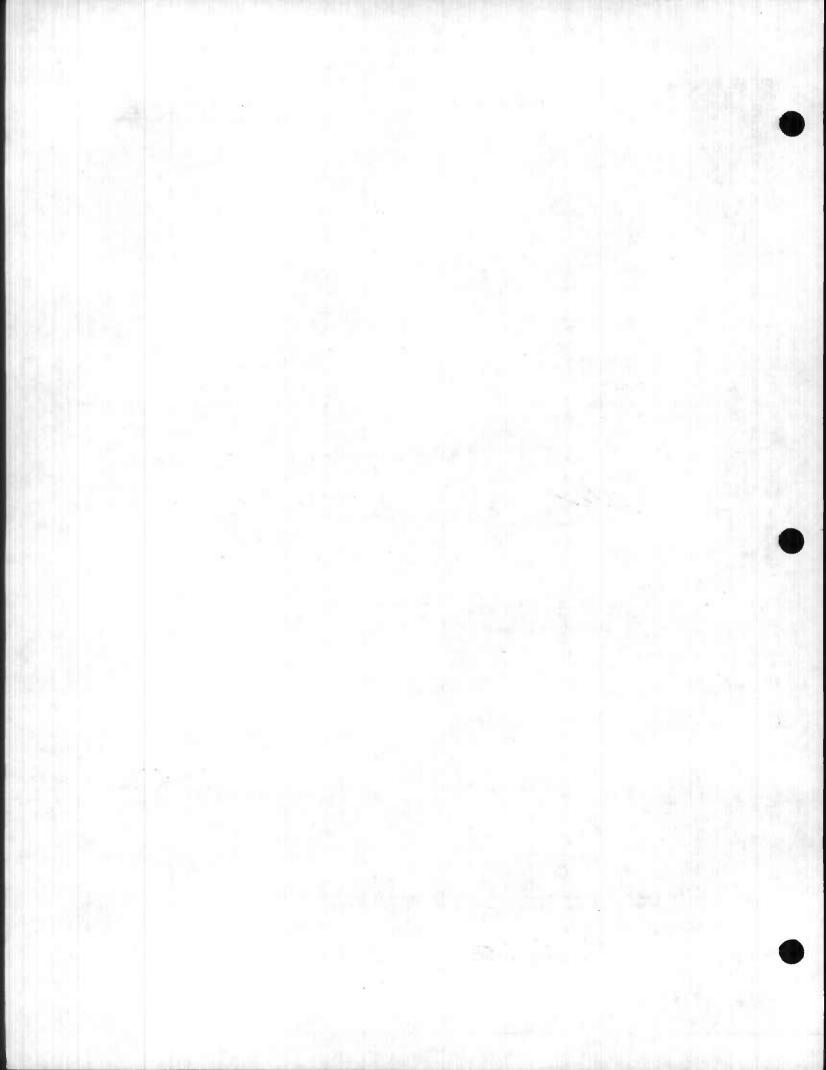
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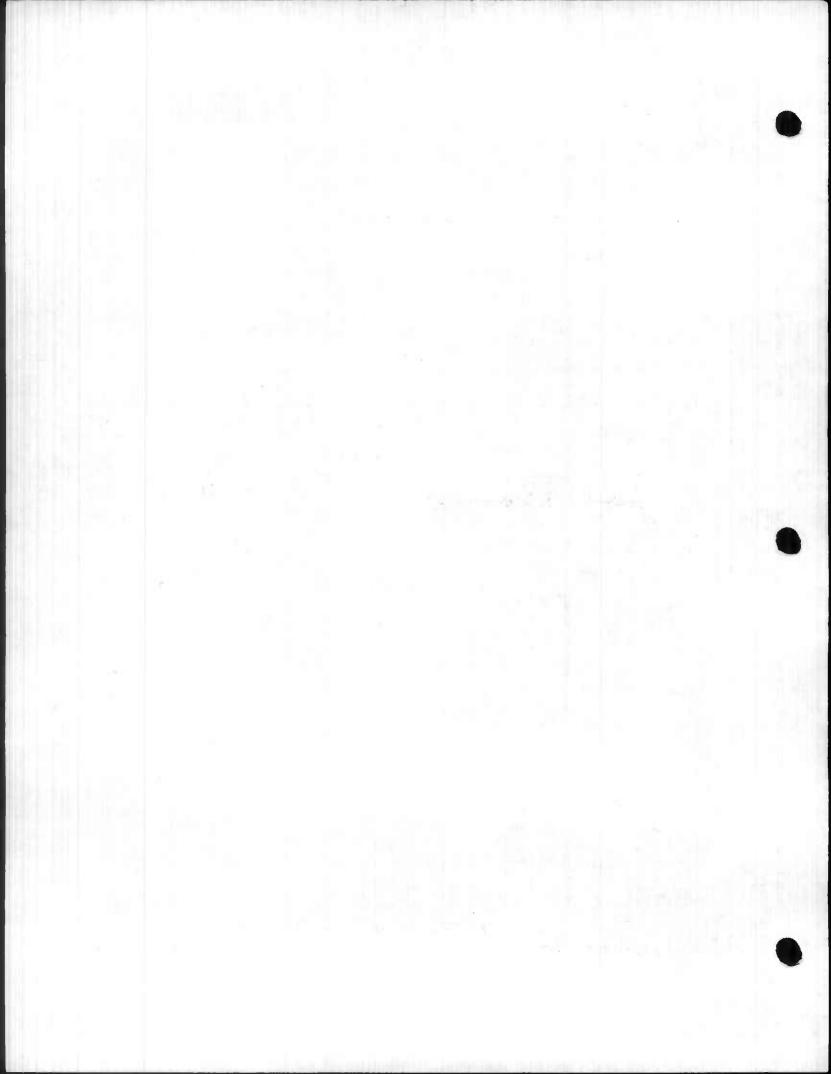
the alth and Mentel Hygiene.  2. So or 28s-f above then "natural, or items 23s or 28s-f above other traumatic event, the Product Examiner must be a political or 10s of 10	ociel Security Number 61-40-6219 el Residence of Decedent Stete 10b. County MD N/A Street and Number 524 N. Charles St., Maritel Status 100 Never Merried 2 Merried 3 Widowed 4 Divorced  (Specify only highest g lementery/Secondary (0-12) Fether's Neme (First, Middle, Last Not known  1. Informent's Neme/Reletionship ancy S. Trueheart-fi	Apt. 505  Apt. 505  12. Wes Deceden Armed Forces 1 Nes 2 Mes Cycle Yes, Give Yes, Give Yes Completed)  College (1-4or 4)	Stre Stre (In yrs. 77 10c. City	Asst birthdey)  7 Yrs.  Homo Mo Mo Mo Mo Mo Mo Mo Mo Mo Mo Mo Mo Mo	Deys  Deys  Do. Zip Code  21201  Decedent of Hos, specify Cube	4b. City, Town, or  Baltimon  If Under 24 Hrs  Hours Min.  Min.  dispanIc Origin? (San, Mexicen, Puerl	s. Dete of Birl (Manth, De March 20	4c. County of N	9. Birthplece (State or F Country) FTOr 1 da  10d. Inside City I 1 V Yes 2 hat Country?  - American Indien, c, While, etc.				
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Na Soe Na Soe Na	ancy S. Trueheart-f	(Type, Print)		19b. Mailing Ad	dress (Street	and Number or Ri			State, Zip Code)				
20e.	Nancy S. Trueheart-friend  4240 Fowler Ave., Baltimore, MD  20e. Method of Disposition  20b. Place of Disposition (Neme of camelory, crametory or other place)  Del												
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29b.	. Signeture end title of certifier	1	,		29c. Licens	se number		29d. Date signed	(Month, Dey, Year)				
+ \ 30.1	Neme end address of person who	o completed cause of	death (Iten	n 23a) (Type, Print		.C.M.E.		Decemb	er 30, 2000				



State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:55 PM 31, December 2000 Estella Mae Brown /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Catonsville Commons Catonsville Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 90 Yrs. Director 212-18-3943 July 17, 1910 Pennsylvania Usual Residence of Decedent 10b. Counts 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No MD Director Baltimore English Consul 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? 2914 New York Avenue 21227 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White P 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important; if item 27 is marked other any Injury or other traumatic event. It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Brown Ila Eishelman 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Mae Deitz (Daughter) 10030 Davis Avenue; Granite, Maryland 21163 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St. John ME Cemetery 1/4/01 Lewisville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, In 21. Signature of Funeral Service Licenses 8728 Liberty Road; Randallstown, Maryland 21133 Mer 406333 from the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and physician ( s the burial-Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 | Yes 2 | No 3 | Probably 4 | Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed peeu has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Be To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Death o the Hospital or Attending Plithin 24 hours after death.
o the Funeral Director: After if xmpletely filled in by the funeral Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner stated. To the Vilhin 2
To the Complete RALM 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Bipin Turakhia, 1009 Frederick Road Baltimore, MD 21228 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

**DHMH 16 Rev 6/95** 

Registrar



Registrar

State

31. Dete filed (Month, Day, Year)

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32. Registrer's Signeture

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111 Penn Street, Baltimore, Maryland 21201

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month Day Yaar M. Huey Dec 28 2000 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Hospital | Undar 1 Year ANNApolis If Undar 24 Hrs. 8. Data of B Arundel Cocheral 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dev. Yaer) 6 Say Birthplaca (Stata or Foreign Country) 1 M 2 X F Months Days Hours 214-76-5263 48 Sept. 23, 1952 Illinois Usual Rasidance of Dacedan 10d. Inside City Limits 10a State 10h Counts 10c. City. Town or Location 1₺ Yas 2□No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3016 Arundel on the Bay 21403 USA 12. Was Dacedant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 13. Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 11☑ Navar Marriad 2 ☐ Married 1 Yas 2K No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) College (1-4or 5+) Disabled | n/a 8th 18. Mothar's Neme (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Harry D Huey MAry Weddle 19a. fnforment's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Francis Weddle / uncle 201 Larkspur LAne Baltimore MD 21220 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of camatery, crematory or other place) Data 20c. Location - City or Town, State 1 XBurial 2 Cramation 3 Ramoval from Stata Holly Hill Cemetery 1/2/2001 Baltimore MD 4 Donation 5 Othar (Spacify) 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice Licensaa Connelly Funeral Home of Essex 300 MAce Ave. Baltimore Md 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final disease or condition resulting in death) CArdIAC Mountes Atrial Sequantielly list conditions, if any, laeding to immadiata ceusa. Entar Undarlying Cause (Disaase or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consequanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2000 3 Probably 4 Unknown Dystrophy, Mental Ketardation 24b. Ware autopsy findings available prior to 24a. Was an autopsy performad? complation of causa of death? 1 Yas 2 No 1 Yas 2 No 25. Was cesa rafarred to medicel exeminar? 26. Placa of Death (Check only ona) 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Menner of Deeth 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury et Work?

**Physician** /Medical Examiner Examiner

**Physician** 

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**Director** 

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Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene.
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Certification: To

2 Accidant 3 Suicida

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29a. Cartifiar

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

certificate Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifica

edicai completely To the I within 2 Registrar

29b. Signatura and titla of certifian

Deputy

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

29c. Licansa number DO6054

1 ☐ Yas 2 ☐ No

29d. Data signed (Mogth, Day, Year)

28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Steta)

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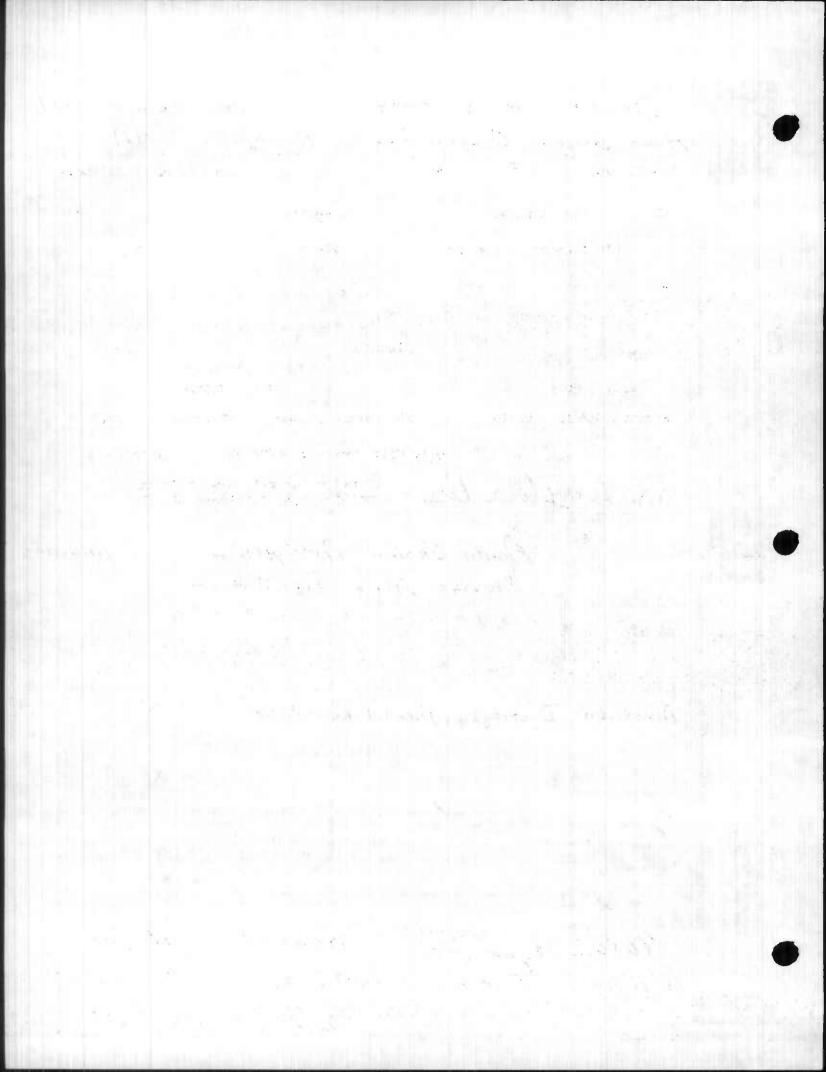
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ONES MO 32. Registrar's Signatura

695 America Ct. 21035

1 Certifying Physician: To tha bast of my knowledga, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated.

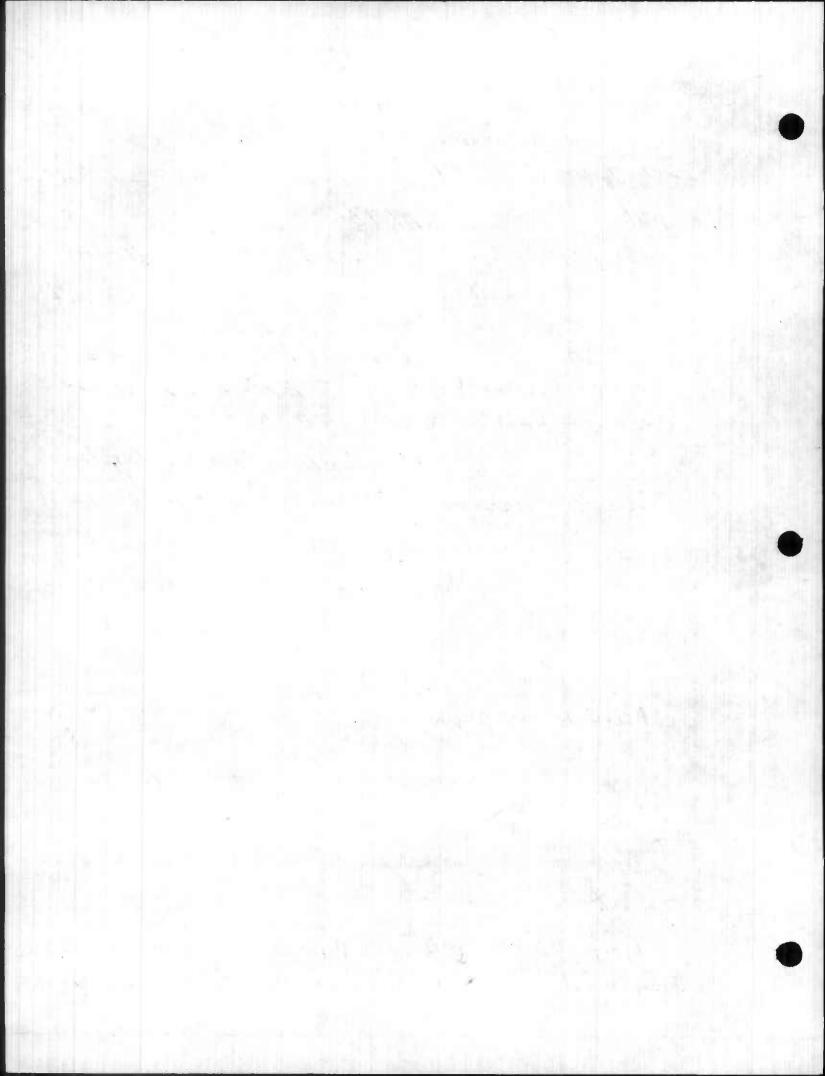
Medical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the causa(s) and manner stated.



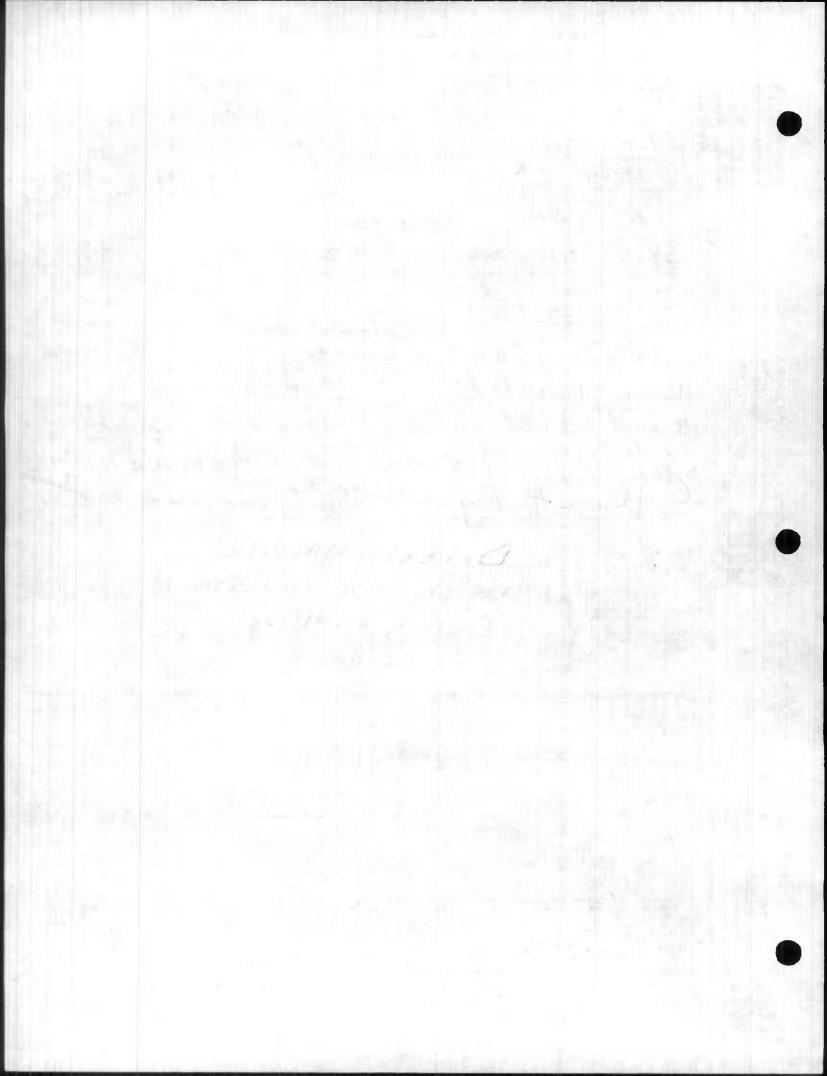
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Deta of Death Day Month **Physician** 13:05 HANKINS GEORGE December 252000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SMMMRITAN HOLPITAL BALTIMORE If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Undar 1 Year 9. Birthplace (State or Foreign **Funeral** Months Deys Hours 1 M 20 F 7-0 Director Usual Residence of Decedent with the Meryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location r le marked other than "naturel", or itema 23a or 28a-f ahow treumatic evant, tre Medical Exeminar mast be notified at 10 Pes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 212 2 72 hours after death 12. Wes Decedent Ever in U,S.
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Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, 11 Maritel Status Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No by Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumama) 17. Fathar's Neme (First, Middla, Last) Be Mental should be h end Mental POR e 9 19b. Meiling Address (Street and Nymber or Rural Route Number, City or Town, 19e. Informent's Nerbe/Reletionship (Type, Print) permit. Pages 1 and 2 st Department of Health end Important: If Item 27 is m any Injury or other treun page. ANKINS SY 20198 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City 1 Burial 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 21. Signetura of Funeral Service Licenses 22. Name end Address of Fecility 3 23a. Pert1. Enter the disease of complications that caused tha death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) SEPSIC Examiner Due to (or as e consequence of): Physician/Medical Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence of): certificata be execut attending physicien end the burial-tra 68760 Due to (or es e consequence of): 80 USB ( Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the 1 Yas 2 No 3 Probably 4 Unknown signed by Renal 2 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Was an autopsy performed? Completed peen s After this certificeta has 1 ☐ Yes 2 ☐ No All or Atternance and a second and a second and a second of Vital 25. Wes case referred to medical examiner? edical Certification: To Be 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatienf 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner es stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier compietely (Check only one) 29b. Signetura and fitla of certifier 29c, License number 29d. Date signed (Month, Day, Year) chawle MO December 25, 2000 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Charole, MD GOVD SAMPRITAN HOUPITAN, RACTIMORE MD LIZZA 32. Registrer's Signetura State Registrar



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	/		Let	e	J	)41901		01-00	5-2001
	do do		30. Nama and address of person who Zigd MIRZA		a) (Type, Print) LURU Pa	rkiway.	Baltino	re Md.	5-2001 21214
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Vesi 1120 km **Physician** 2000 JOSEPH JAMES /Medical 4b. City Town, or Location of Deeth 4c. County of Death 4e Facility Nema (If not institution, giva street end number) Examiner BALTMORE MUNES HSDITAC If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) NA 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** 1**X** M 2□ F 67<sup>Yrs.</sup> Months Director NOV. 10, 249-48-0057 Usuel Residence of Decedant SC the Maryland 10e State 10b County 10c. City. Town or Location 10d. toside City Limits "natural", or items 23a or 28a-f show 1X Yes 2 No Director NA BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? USA death Funeral 858 FAYETTE STREET 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Yaar or Detas: Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Energies and Bleck, White, etc. 1 Never Merried 200 Married Specify: AFRICAN 1 Yes 2X No Specify: P 3 ☐ Widowed 4 ☐ Divorced AMERICAN
16b. Kind of Business/Industry Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondary (0-12) Collega (1-4or 5+) 8th NA CONSTRUCTION/STEEL WORKER STEEL 18. Mother's Nama (First, Middle, Maiden Sumeme) 17. Fathar's Neme (First, Middle, Last) Be JOSEPH JAMES NORA ISSAC 19e. tntorment's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) 858 FAYETTE STREET BALTIMORE MD 21201
t Disposition (Nema of Deta 20c. Location - City or Town, State GLORIA CLAYTON 20b. Plece of Disposition (Nema of cemetery, cremetory or other place) 20e. Method of Disposition 1 XBuriel 2 Cremation 3 Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) VOSHELL MEMORIAL GARDENS 1/4/01 DUNDALK, MD 21. Signature of Fundati Service License 22. Name end Address of Facility WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE. 21217 MD 23a Part. Enter the destate, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Batween Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medicat Da Examiner Dua to (or as a consequence of) Physician/Medical Examine Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence ot): physician the burial O. Box 68760, ž Due to (or es a consequence of): attending pl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? SWAL 1 Yea 2 No 3 Probably 4 Vinknown Division of Vital Records. P. g 24b. Ware autopsy tindings eveileble prior to complation of ceuse of death? 24e. Was an autopsy performed? Completed i certificate has il 1 Yas 2 No 1 ☐ Yes 2 ☐ No IAME CANAGE Be 25. Wes cese reterred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yas 2♥ No 1 Impatient 2 ER/Outpatient 3 DOA 27. Mennar ot Death Certification: 28d. Dascribe how injury occurred 1 Naturel 2 Accident 5 Pending invastigetion 1 Yas 2 No 6 Could not be detarmined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicida Hospital or To the Hospital owithin 24 hours at To the Funeral Dicompletely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier edicai (Check only one) 29b. Signature and title of certifies 29d. Date signad (Month, Day, Year) 30. Name and eddress of person who completed code ot deeth (Item 23e) (Type, Print) BALTIMUEE, 21229 ALEXANDER Jo Houson, 900 31. Data tiled (Month, Dey, Year) 32. Registrer's Signeture State Registrar 200Ks JAN 0 9 2001 DHMH 16 Rav 6/95

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death BERTHA Day Year TONES DECEMBER 31 8:44 AM 2000 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore N/A If Under 1 Yaar | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 2Ĭ F Days Months Hours 175-14-8986 79 MAR 30. Pennsylvania Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland N/A Baltimore fX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1341 Crofton Road 21239 USA 11 Maritat Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Bustness/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Public School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Frank Jones Mattie Dozier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 7112 Wiltsie Street Hardie Dozier/Brother Pittsburgh, PA 15206 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Ramoval from Stafe
4 Donation 5 Other (Specify) Metro Crematory Inc. 1 - 5 - 01Baltimore, MD 21. Signature of Funeral Service Licenses

Daniel F. McDorral 22 Name and Address of Feeility of MD, Inc. C McDonald 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final . ACUTE MYOCARDIAL INFARCTION HOUR disaasa or condition resulting to death) Dua to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yas 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Hospitat: 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

physician and s the burial-transit

attending p

that the death certificate be executed

Box 68760

Examiner

Physician/Medical

p

Completed

Be

Certification: To

edical

**Physician** 

/Medical

Examiner

10a Stata

**Funeral** 

Director

r than "natural", or flams 23a or 28a-f show the Medical Examiner must be notified at

Funeral Director

þ

Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

pernit. Pages 1 end 2 should be filed withit Department of Health end Mental Hygiene. Important: if item 27 ie marked other than any Injury or other traumerin.

Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Diseese or injury that initiated events resulting to death) Last

Pert II. Other significant conditions contributing to death but not resulting to the underlying cause given in Part I.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Division of Vital Records, P.O.	To the Hospital or Attending Physicien: The lew requires that the dewithin 24 hours effer deeth.  To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it.
Division	To the Hospital or Attending within 24 hours effer deeth.  To the Funeral Director: After completely filled in by the fune

1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending investigation 2 Accidant

3 Suicide

28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 TYes 2 No

6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner es stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the fime, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

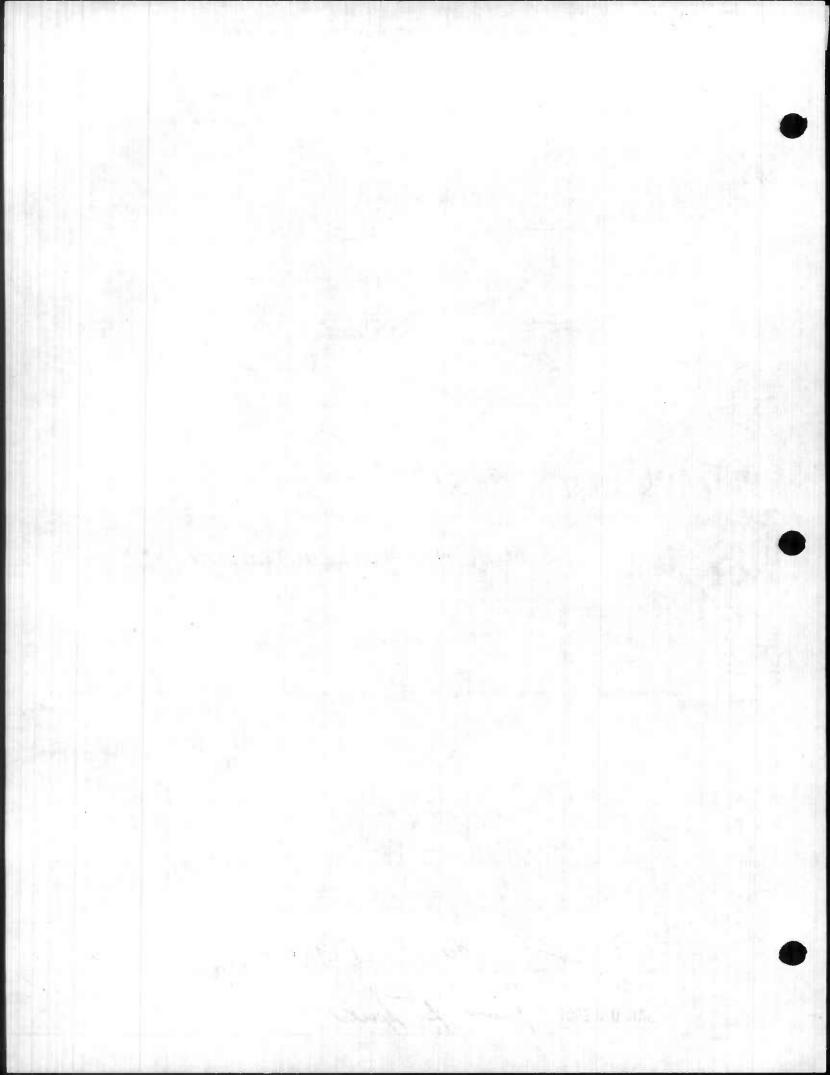
29b. Signatura and fitle of certifier

29c. License number P19264 29d. Date signed (Month, Day, Year) DECEMBER 31, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BOULEVARD, BALTIMORE, NGUYEY SAMARITAN HUSPITAL GOOD MD 21239

State Registrar

31. Data filed (Month, Day, Year) JAN 0 9 2001 32. Registrar's Signature



		State of Maryla		artment or <i>rtificate</i>				giene (	42	2747
	1. Decedent's Neme (First, Middle, Last	)					2. Dete of Dec		Vaar	3. Time of Death
Physician /Medical	FRANKLIN	MARTIN	KI	MELMAN	1		Month DECEMBE	ER 31, 2	Yeer 2000	9:45 AM
Examiner	4e Fecility Name (If not institution, give	street and number)			41	b. City, Town, or	Location of Deeth	4c. County	of Deeth	
	HAMMONDS LANE NUI	RSING CENTER				BROOKLY		ANNE	ARUN	NDEL
eral ctor	5. Social Security Number 6. Se 216-07-9253 Usuel Residence of Decedent	7	s. lest birthdey)	If Under 1	Year Deys	If Under 24 Hrs Hours Min	. (Month, De	h v. Year) 30,1918		laca (Stete or Foreign itry) LAND
notified at rector	10a. Stete 10b. County  MARYLAND ANNE AR		City, Town or Lo	BURNIE					1	0d. Inside City Limits 1 ☐ Yes 2 🛱 No
4 0	10e. Street end Number 5805 ELKINS STREE	T		10f. Zip Co		1061		10g. Citizen of U.S.		ntry?
Examiner must by Funeral	11. Merital Status  1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?  1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Dates:	1942-	Wes Deceder if Yes, specify 1☐ Yes 2页		spenic Origin? (. n, Mexicen, Pue Specify:	Specify Yes or No- rto Rican, etc.)		ce - Americ ck, White, v: WH]	etc.
r, the Medical	15. Decedent's Edu (Specify only highest grad	e completed)	16e. Deca (Give life.	dent's Usuel ( kind of work of DO NOT use	Occupa done d retired)	tion u <i>n</i> ing most of we	orking	16b. Kind of B	usiness/Ind	dustry
	Elementery/Secondary (0-12)	College (1-4or 5+)		ER PLU		R		PLUMB:		
BeC	17. Fether's Neme (First, Middle, Last)						ime (First, Middle,			
2	FRANKLIN MARTI  19a. Informent's Neme/Relationship (T)		-		Ctroot o	JULIE	Rural Route Numbe	BERLI		Codel
	MRS. JEAN KIMMELM						LEN BURN			
	20e. Method of Disposition  1 Burial 2 Cremetion 3 4 Donetion 5 Other (Specify,	20b. Removal from State	Plece of Dispo cemetery, cre	osition (Name metory or othe	of er plece	э)	01/08/20 TER, LLC	20c. Location	City or To	own, Stete
once.	21 Signature of Funeral Service Licens	00	2:	2. Name and	Addres	s of FecilitySI	NGLETON S.W., GL	FUNERAL	HOME	, P.A.,
cian	23a. Pert1. Enter the disease, or condishook, or heert feilure. List only o	ications that caused the dene ceuse on each line.		ter the mode o			ac or respiretory er	rrest,		Approximate Intervel Between Onset end Death
ner	disease or condition resulting in deeth)	9.	(or es a conse		720					3 0013
al Examiner		Acute	Anem	ia						2 wks
n/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	Arterio-V	(or es e conse	quence of):  Malf	orn	nation	of Co	lon		2 yrs
Physician/Mec	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.  23b. Did tobacco use contributing to death but not resulting in the underlying ceuse given in Pert I.									
Completed by							24a. Wes	en eutopsy med?	av	2 yrs  ribute to the cause of death?  3 Probably 4 Unknown  24b. Were eutopsy findings aveilable prior to completion of cause of death?  1 Yes 2 No
Сотр							101	res 2/2 No		
Be Scior	25. Wes cese referred to medical exeminer?  1  Yes 2 No	Hospitel: 1 ☐ Inpatient 2	TER/Outerstie	nt 3 DOA	Othe		eeth (Check only o		or /Cancil	(v)
Certification: To	27. Manner of Deeth  1  Neturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury		. Injury Work	4 Z Nursing	28d. Describe i	now injury occur	rred	
ertific	3 Suicide 6 Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, farm, st	reet, factory, o	office		28f. Location (S City or Tox		ber or Rura	al Route Number,
Medical Cert	29e. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kr ner: On the basis of examin end menner stated.	nowledge, deat netion end/or in	h occurred et vestigation, in	the tim	e, date end plac inion, death occ	e, end due to the curred et the time,	ceuse(s) end m date end plece,	enner es s end due to	iteted. o the ceuse(s)
W Comp	29b. Signeture end title of certifier	26.23				number		29d. Date signe	ed (Month,	Day, Year)
	30. Neme and address of person who co	mpleted cause of death (b)	om 23e) (Type		54	+736		12	131	/00
)		M.D., 9000 I			RE I	DRIVE. F	BALTIMORE	. MD. 2	1237	

Registrar

2001 JAN -9 AM 1:58

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#26 perPHYG791 1/9/2001 EW Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Day PRUDER 5HIRLEY 22=00 12 2000 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death HARFOND EN UPPER CHEJAPEAKE MED CIR BELAIR 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 1□ M 2♥ F 65 Yrs. 371-32-1416 Usuel Residence of Decedent Jan.30,1935 Detroit, Michigan 10a, Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No N/A Honolulu 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 96816 2936 Alphonse Place 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify. Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondery (0-12) Dental Industry Dental Hygienist 12 years years 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Rita (unknown) J.R.Bullington 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 2936 Alphonse Place Honolulu HI 96816 Gary D. Pruder (husband) 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 12/30/2000 baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory 22. Name and Address of Fecility E.F.Lassahn Funeral Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ND as shock, or heart failure. List only one cause on each line. 21087 Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) ASCUD Due to (or es e consequenca of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of)

by Physician/Medical Examine The lew requires that the death certificate be executed the ettending physicien Division of Vital Records, P.O. signed by Medicai Certification: To Be Completed or Attending Physician: s after death.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or itsens 23s or 28s-f show

Baltimore, Maryland 21215-0020

should be filed within

Pages 1 and 2

Health Hem 27

permit. Pages Department of Important: if it any injury or of

**Physician** 

/Medical Examiner

the Medical Examiner must be notifi-

Directo

Funeral

by

Completed

Post II. Other classificant and distance	and the state of t	nulling to the angle had		a street in Root I	22h Did tohacco usa os	entributs to the cause of death?	
Pert II. Other significant conditions co	IPERTEN		ng caus	se gwen in Perci.	1 ☐ Yes 2 No	3 Probably 4 Unknown	
					24a. Wes en eutopsy performed?	24b. Were eutopsy findings aveilable prior to completion of cause of death?	
					1 ☐ Yes 2 No	1 Yes 2 No	
25. Was case referred to medical exempiner?				26. Place of De	eath (Check only one)		
1 No	Hospitel: 1 ☐ Inpatient 2 ☐	ner (Specify)					
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c.	Injury at Work? 1 Yes 2 No	rred		
3 Suicide 6 Could not be determined	28e. Pleca of Injury - At I building, etc. (Spec	nome, farm, street, fe	28f. Location (Street and Number or Rural Route Number, City or Town, State)				

State Registrar

filled in by

To the Hospital or within 24 hours aft To the Funeral Di completely

> 31. Date filed (Month, Day, Year) JAN 0 9 200

40

30. Name end address of person who completed cause of death (Item 23s) (Type, Print)

29b. Signeture end title of certifie

PRABHO

728 BELANN 32. Registrer's Signeture

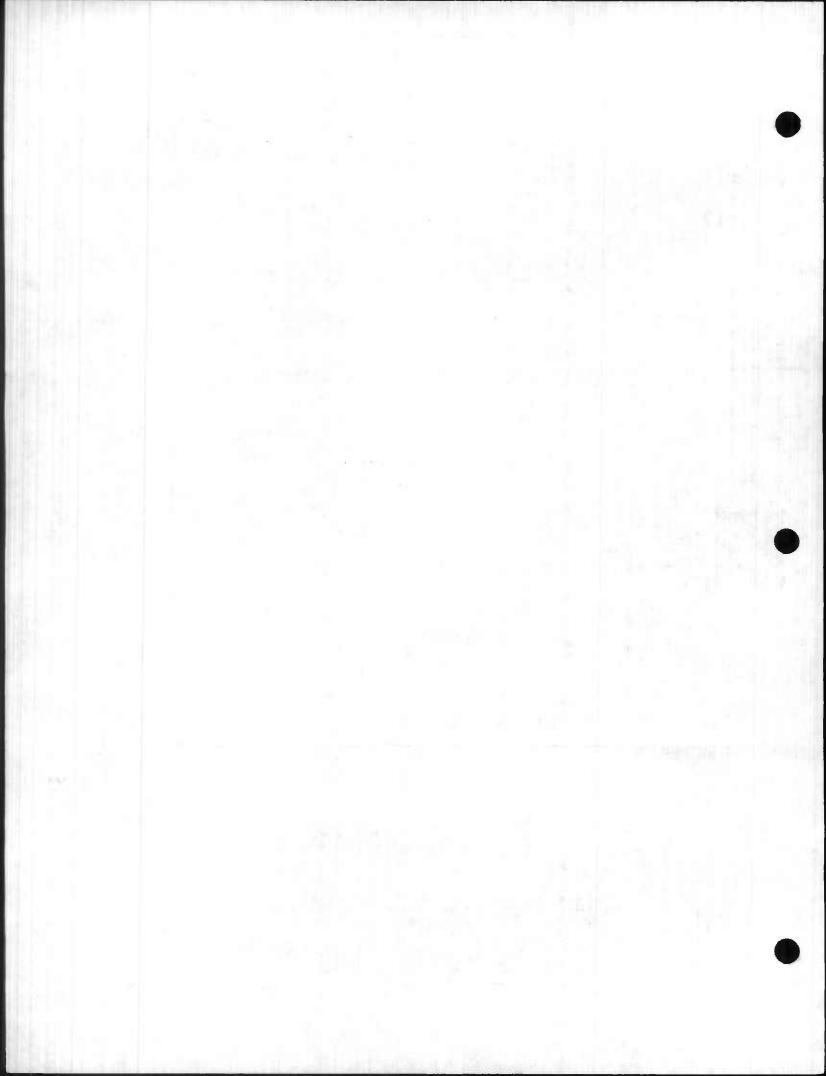
BUAN MO 21014

29c. License number

29d. Date signed (Month, Dey, Year)

DEZ 27, 2000

DME



State of Maryland / Department of Health and Mental Hygiene n Amended Item#20b,20c perFH,#23a perPHYG791 1/9/2001 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Pear1 Sparks 4b. City, Town, or Location of Death 21 2000 1647 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner The Memorial Hospital Easton
If Under 1 Year | If Under 24 Hrs. | 8, Date Talbot 5. Social Securify Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 1 M 280 F Months Days Hours Min. Yrs. 217-12-4449 Ridgely, MD **Director** 92 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health end Mental Hygiene.
ant: If Item 27 is marked other than "natural", or frams 23s or 28s-4 show ury or other traumatic event, the Medical Examinat must be notified as Yes 2 No Directo Goldsboro Caroline 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21636 25730 Castle Hall Ecad Funeral 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 2 No Specify: Specify: black þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer Green Giant Corp. Sparks 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Black Clara Black 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health e Important: if item 27 is any injury or other trai 25730 Castle Hall Road Goldsboro, MD William B. Patton Baltimore, Pearl 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Qther (Specify) 5/26/2000 Goldsboro, Md New Union Ourch Cemetery 22. Name and Address of Facility The House of Wright Mortuary P.O.Box 447 Wilm., DE 19899 23a. Part1. Enter the disease, of complications that contact the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one couse on much line. Approximate Interval Between Onset and Death Physicin<sub>n</sub> 71.12 Sical Immediate Cause (Final disease or condition resulting in death) 96 hours esmatie Examiner Due to (or as a consequence of): Physician/Medical Examiner **PNEUMONIA** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco uss contribute to the cause of death? detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. The law requires that the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown been signed by by Division of Vital Records. page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed Preumon this certificate has 2 No 1 Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 2 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: After or Attending 1 Metural 2 Accident 5 Pending investigation after death.

Diractor: Aft
d in by the fu 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D completely filled Certifying Physician: To the best of my knowledge, death occurred at the tima, dete end place, and due to the cause(s) and manner es steted.

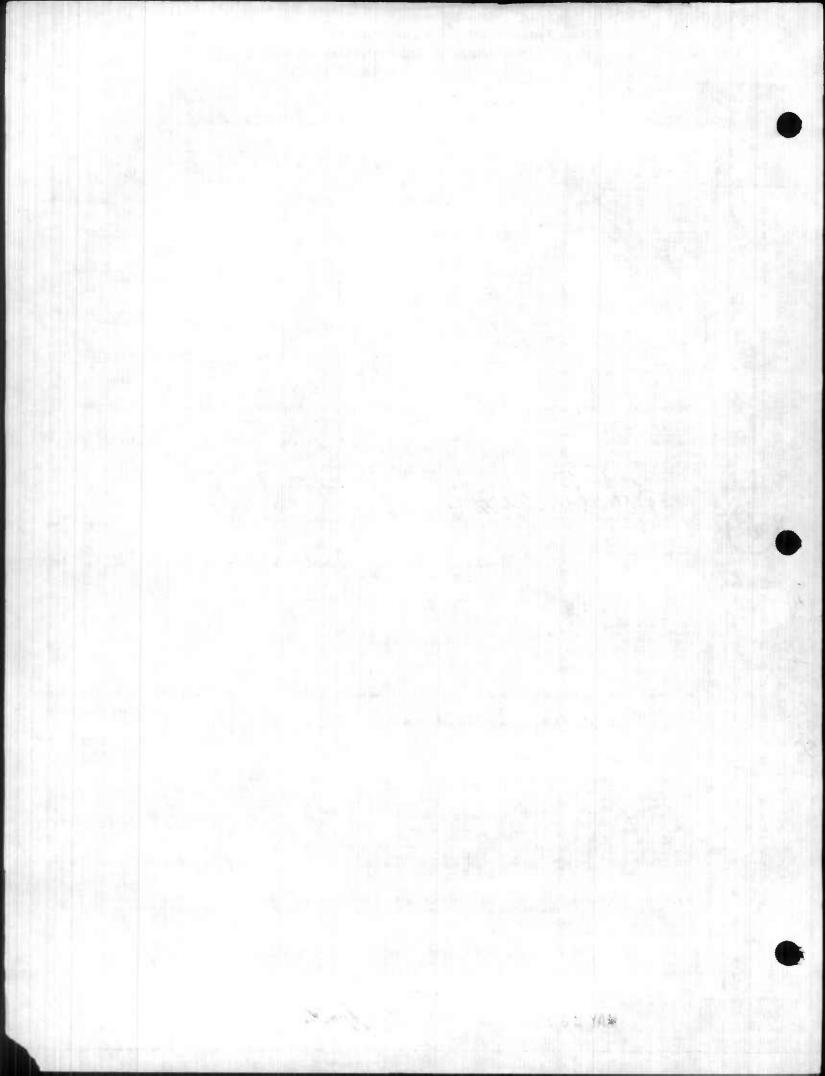
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) 29a. Certifier edicai and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signeture and title of cartifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Hospital Mary Spencer Deshields 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

MAY 23 2000

book



State Registrar 31. Date filed (Month, Dey, Year) JAN 0 9 2001

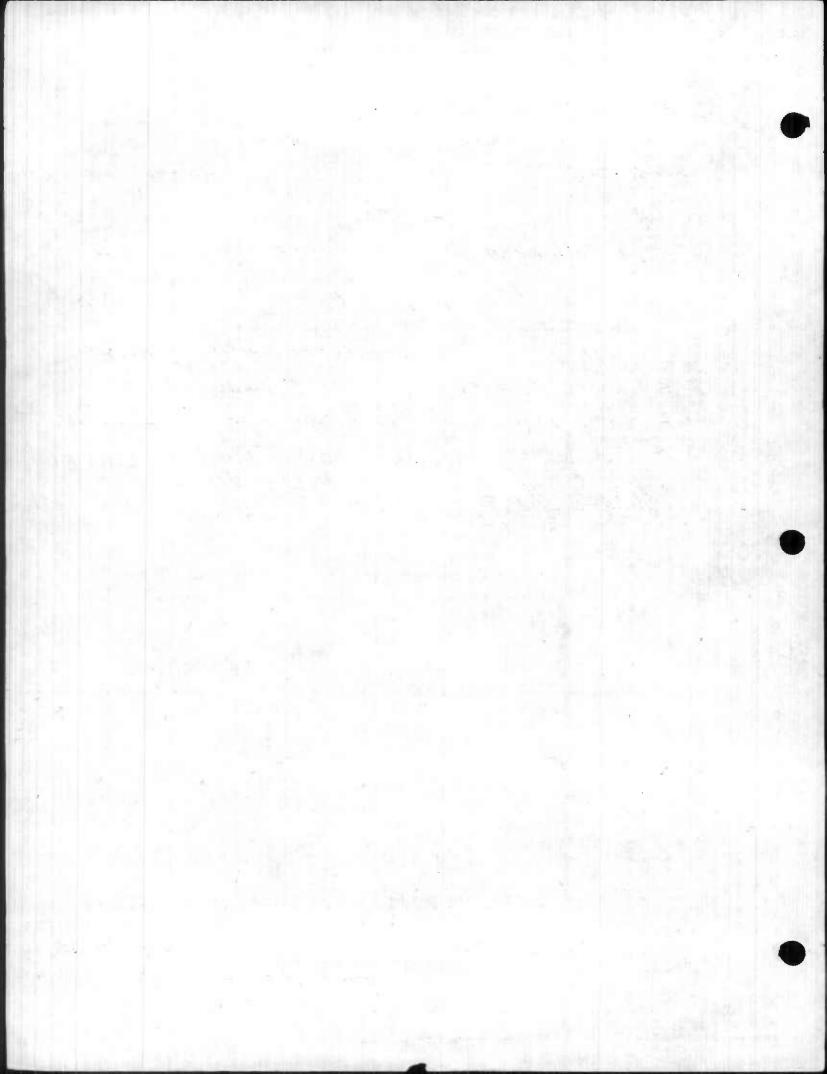
JACK MI

32. Registrar's Signature Jane

miD.

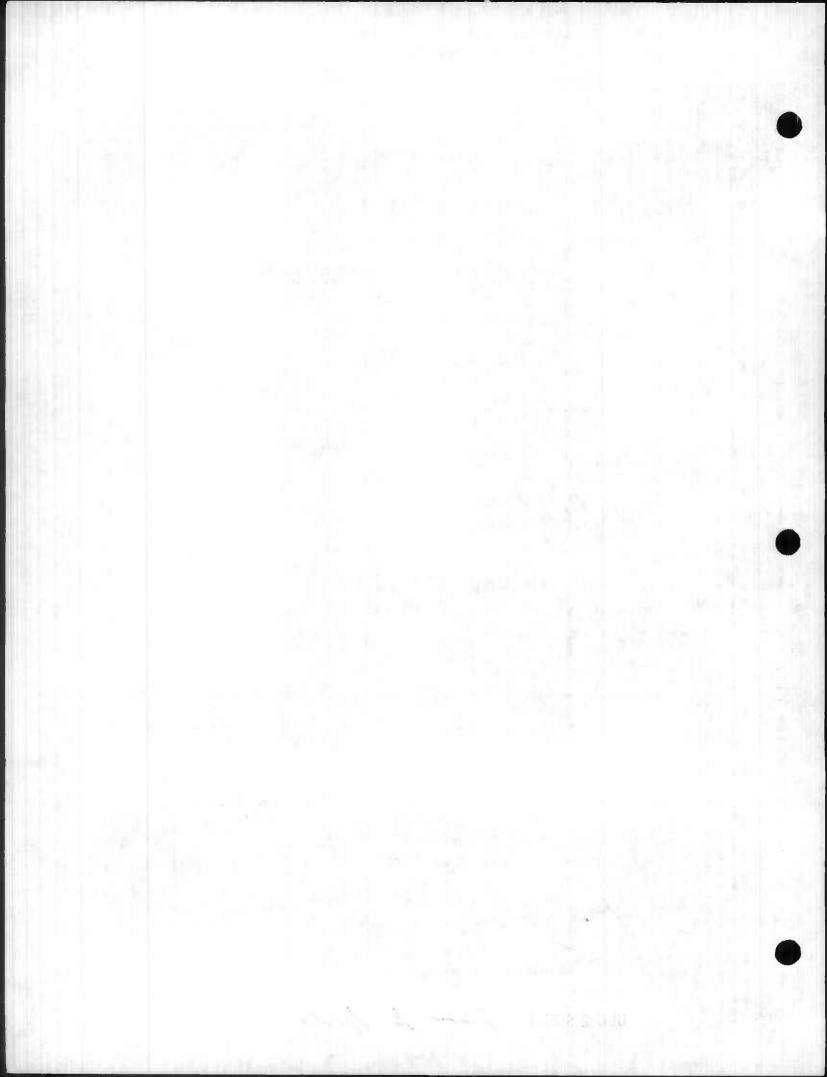
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State of Maryland / Department of Health and Mental Hygiene 0 1, 27 = 1

				Certifica	te of	Death	R	eg. No.	42	1151		
	1. Decedent's Name (First, Mic	idia, Last)					2. Date of Deal Month	th Day	Year	3. Time of Death		
Physician /Medical			APPEL				DECEMBE		2000	7:36AM		
Examiner	4- Contito Manne (Mant Inntitu	ion, give street and number;	)	est( )s		4b. City, Town, or	Location of Death	4c. County				
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Ju.D	30. Nama and address of person	on who complated causa of	daath (Itam 23a)	(Type, Print)								
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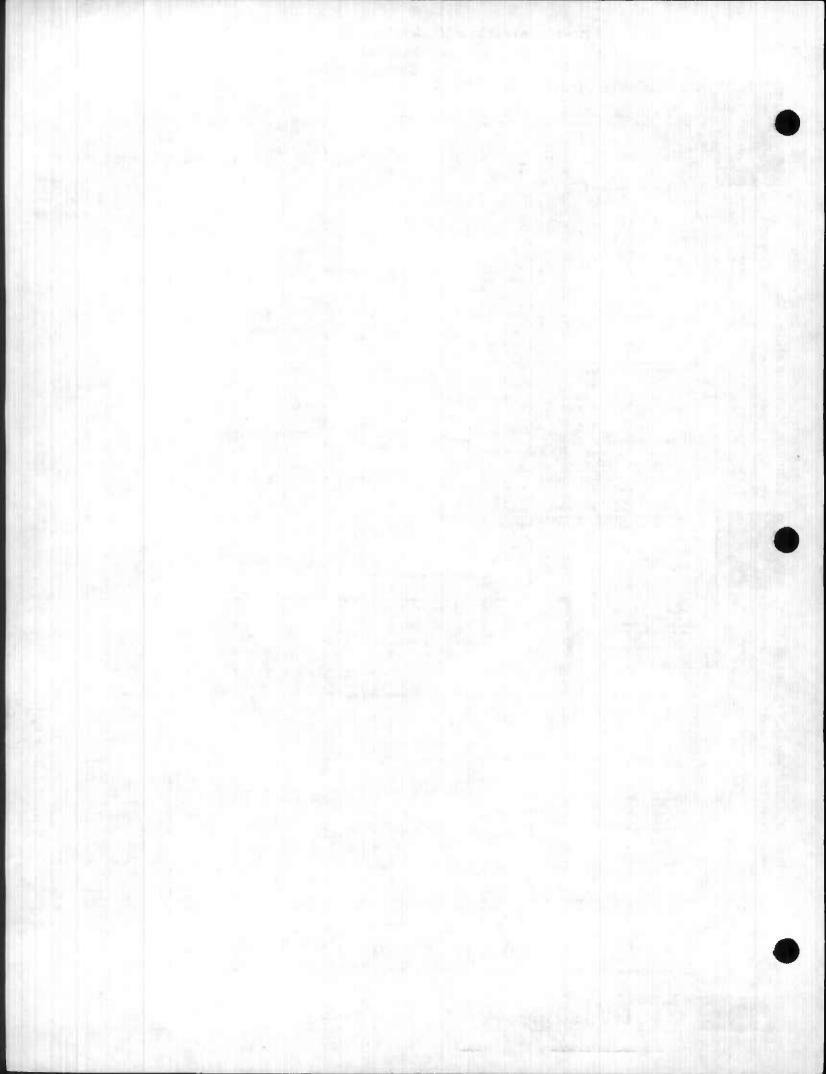
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** 23 2310 Dec. Arwood Orville Jay /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Bethesda Montgomery Suburban Hospital If Under 24 Hrs. 5. Sociel Security Number 6 Sax 7. Age (In yrs. last birthday) If Under 1 Yeer Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** Months Deys 1**X** M 2□ F Hours Yrs. Washington, DC August 10 1956 Director 220-70-8808 44 Usuel Residence of Decedent 72 hours efter deeth with the Meryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f show Pages 1 and 2 should be filed within 72 hours efter death with the Marylas nant of Heelih and Mantel Hygians.
with: If them 27 is marked other than "natural", or frame 23a or 28a-f show ury or other treumatic event, in a fraction of the morth or and the morth or the treumatic event, in a fraction of the morth or an experience. 1 ☐ Yes 2 ☑ No Director Rockville MD Montgomery 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 20852 10404 Rockville Pike United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give 'Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Maritel Status Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: Saltimore, Maryland 21215-0020 þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) Urban Institute Administrator-Computer 12 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Joyce May Arwood Marion Orville 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth e Important: if item 27 is eny injury or other tree page. 10404 Rockville Pike, #202, Rockville, MD 20852 May/Mother Joyce 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) Dec.26 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory Inc 2000 Beltsville, MD 22. Name and Address of Facility Rapp Funeral & Cremation Serv. Stephen D. Lohrmann, PA 933 Gist Ave. Silver Spring, MD 20910 21. Signeture of Funeral Servica Licanses 23a. Perfl. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting In deeth) carcinoma of bladder Examiner Due to (or es e consequence of): Physician/Medical Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest and Due to (or as e consequence of): es the burial-trer Box 68760. the attending physician Due to (or es e consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown by Division of Vital Records, 24b. Were eutopsy findings evelleble prior to 24a. Wes en eutopsy performed? Completed completion of cause of deeth? this certificate hes 2 No 1 Yes 1 ☐ Yes 2 No septal or Attending Physicien: Theoris after death.
Inersi Director: After this certificate yfilled in by the funeral director, pa Be 25. Wes case referred to medicat 26. Plece of Death (Check only one) Hospitel: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medicai Certification: To 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of cartifier Patricia L. Tomsko, 2000 12 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) ville 11140 lomako, MD, Rock Pike, PMB 348, Rockville, MD 20852 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State

**DHMH 16 Rev 6/95** 

Registrar

**DEC 26** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 1, 2753 Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Det Month MARION 1255 AM STED-DOM 2000 NY 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) HOSPITA रिजीविक के MONTGONEDY SURULBAN If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 7. Age (In yrs. lest birthdey) 9. Birthplace (Stete or Foreign 5 Social Security Number 6 Sex 8. Date of Birth (Month, Dey, Year) Hours 10 M 20.F 81 125-05-4655 AUGUST 11, 1919 NEW YORK Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b Counts X□ Yes 2□ No ROCKVILLE MARYLAND MONTGOMERY 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code USA 10101 GROSVENOR PLACE #1104 20852 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 □ Never Married 2 □ Married 1 Yes ¾□ No Specify: It Yes, Give Yeer or Detes: WHITE Specify: 3 N Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) PARTY PLANNING GOURMET COOK 12 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) ROSE KOSLOW ABRAHAM GRUNSTEIN 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a, Intorment's Name/Reletionship (Type, Print) 12603 BLACK SADDLE LANE, GERMANTOWN, MARYLAND 20874 ROBERTA SPOLIN/DAUGHTER 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition DEC 27. 1 Burlel 2 □ Cremetion 3 □ Removel from Stete OLNEY, MARYLAND 2000 HIDEAN MEMORIAL GARDENS 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fed DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 02852 Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset end Deeth ACUTE MYELOGENOUS Immediete Ceuse (Finel LEVKOMIA disease or condition resulting In deeth) Due to (or es e consequenca ot) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence ot): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy tindings eveilable prior to 24e. Wes en eutopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No 26. Place of Deeth (Check only one)

**Physician** /Medical Examiner

certificate be exec Box 68760.

P.O.

Division of Vital Records,

Hospital or Attending Physician:

efter death. Director: Af

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To the Hosp within 24 hor To the Fune completely fi

**Physician** 

/Medical

Examiner

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29e. Certifier (Check only

edical

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner es stated.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner stated.

29b. Signature end title ot certifier

29c. License number 015236 29d. Date signed (Month, Dey, Year) DECOMBER 25, 2000

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

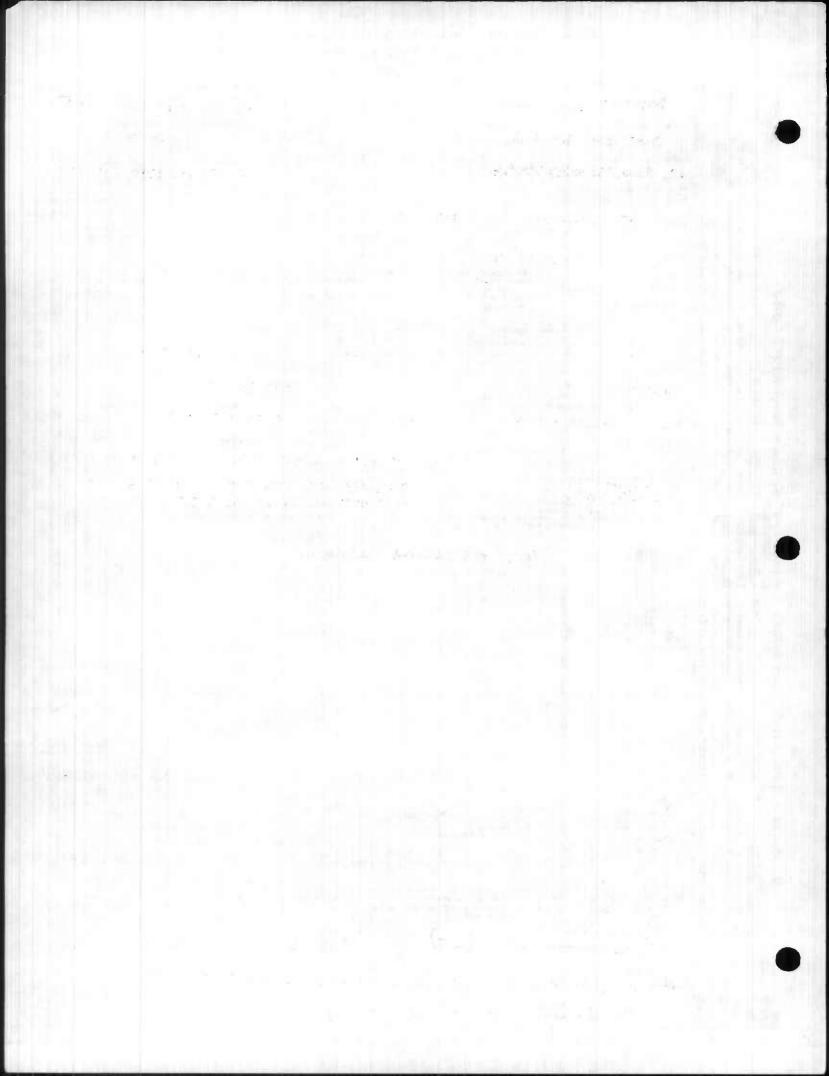
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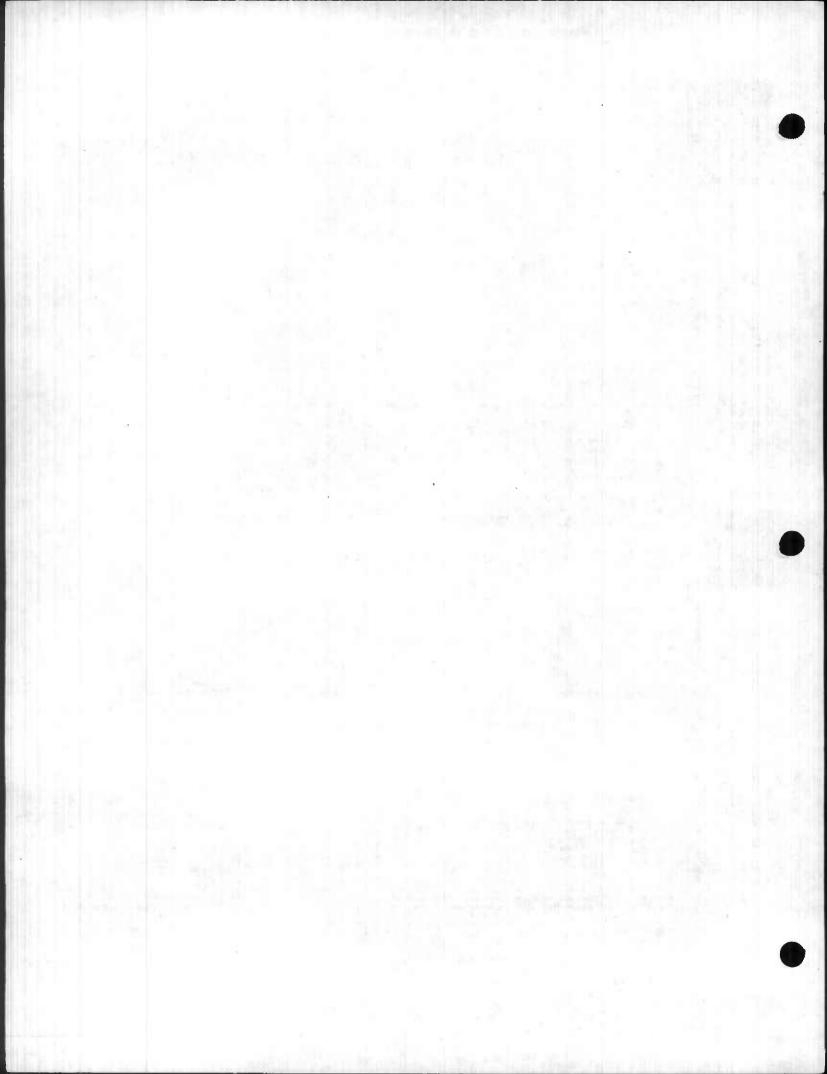
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State of Maryland / Department of Health and Mental Hygiene 0 1, 27

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or he	by Funeral Director	11. Marital Status  1 ☐ Never Merried 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Deceda Armed Forca 1 Yes 2 If Yas, Giva Yaar or Data	is? ≩No				Hispanic Origin? ( ean, Maxicen, Pue Specify:	Specify Yas o nto Rican, atc.	r No-		e - Amarica k, White, e	etc.	
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Mar 12 sh 12 sh 18 m	A	19a. Informant's Name/Ralationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Num Elizabeth Lee Beard / Daughter 296 St. John's Road, Drums,												
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Physician /Medical Examiner	er	234-Part1. Entar tha diseasa, or com- shock, or heart failure. List only Immediata Cause (Finel diseasa or condition rasulting in death)		zheime	er's Di	seas	e						Intarvel Batween Onset end Death	
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		30. Nama and addrass of person who Brian Shneier, I					D1e=	#2 0	01		Van-1	. 1 . 0	1045	
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State of Maryland / [

Department of Health and	Mental Hygiene	n	- 1.	2	7	5	5
Certificate of Death	Reg. No.	U	4	-	1	U	U

Physician
/Medical
Examiner

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Data signed (Month, Day, Year)

DECEMBER 23, 2000

's County,

28f.

**Funeral** Director

the Maryland "netural", or items 23s or 28s-f show adical Examiner must be notified at r then "netur Hygiene.

filed within 72 hours efter death with Baltimore, Maryland 21215-0036 7 le marked other traumatic event, I permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy Imporant: If Item 27 is marked other any injury or other traumatic event pates.

> **Physician** /Medical Examiner

physician and s the buriel-transit the deeth certificate be execu P.O. Box 68760. 88 use for signed by the a Division of Vital Records, peeu pege 2 hes certificate Hospital or Attending Physician: director, this funeral After r death. after deatl Director: the 3 n 24 hour. Ne Funerei Dir. To the Hosp within 24 hos To the Fune completely fi

1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Time of Death Month DECEMBER 22, 2000 19:53 PM JEAN LEONIE ALLEN 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth WASHINGTON ADVENTIST TAKOMA PARK MONTGOMERY If Under 24 Hrs. 8. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) Dete of Birth (Month, Day, Year) Days Min. Months Hours 1 M 2 XF 55 218-27-0799 12-01-45 St. James, Jamaic Usual Residence of Deceden 10a State 10c. City, Town or Location 10b. County 10d. Insida City Limits 1 ▼Yes 2 No Directo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Apt. 102 8202 Newhampshire Avenue 20903 U.S.A Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Detes: 14. Race - American Indian, 11. Marital Stetus Bleck, White, etc. 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No Specify: **Black** Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Patient Escourt 12th Health Care 18. Mother's Name (First, Middla, Maiden Sumama) 17. Fether's Neme (First, Middle, Last) Be UNKNOWN EDNA EUNICE ALLEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20903 19e. Informent's Neme/Reletionship (Type, Print) 8202-Newhampshire Ave. Apt. 102 Silver Spring, Md. KERON HARRIS-BEEKO/ DAUGHTER 20b. Plece of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20e. Method of Disposition 1 Deuriel 2 Cramation 3 Ramoval from Stata PYE RIVER CEMETERY 1-04-01 Montego Bay, Jamaica 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Bianchi Funeral Service M. Signatura of Eunerel Service Licensee 814 Upshur Street, N.W. Washington, D.C. 20011 delin 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Ceuse (Final disaese or condition resulting in deeth) Examine Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or es a consequance of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Was an autopsy performed? Completed 1 HYes 2□ No 1 PYes 2 □ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 XYes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury et Work? Certification: Edestrian Struck by 1 Neturel 5 Pending investigation 1921 1 Yes 2 No 22/00 2 Accident

State Registrar

0

edicai

**DHMH 16 Rev 6/95** 

31. Dete lied (Month, Day, Year) DEC 2 9 2000

Besep

6 Could not be determined

3 Suicide

29e. Certifier

4 Homicide

(Check only one)

29b. Signature end title of certifier

25 32. Registrar's Signetura merra

oss of person who completed cause of deeth (flem 23a) (Type, Print)

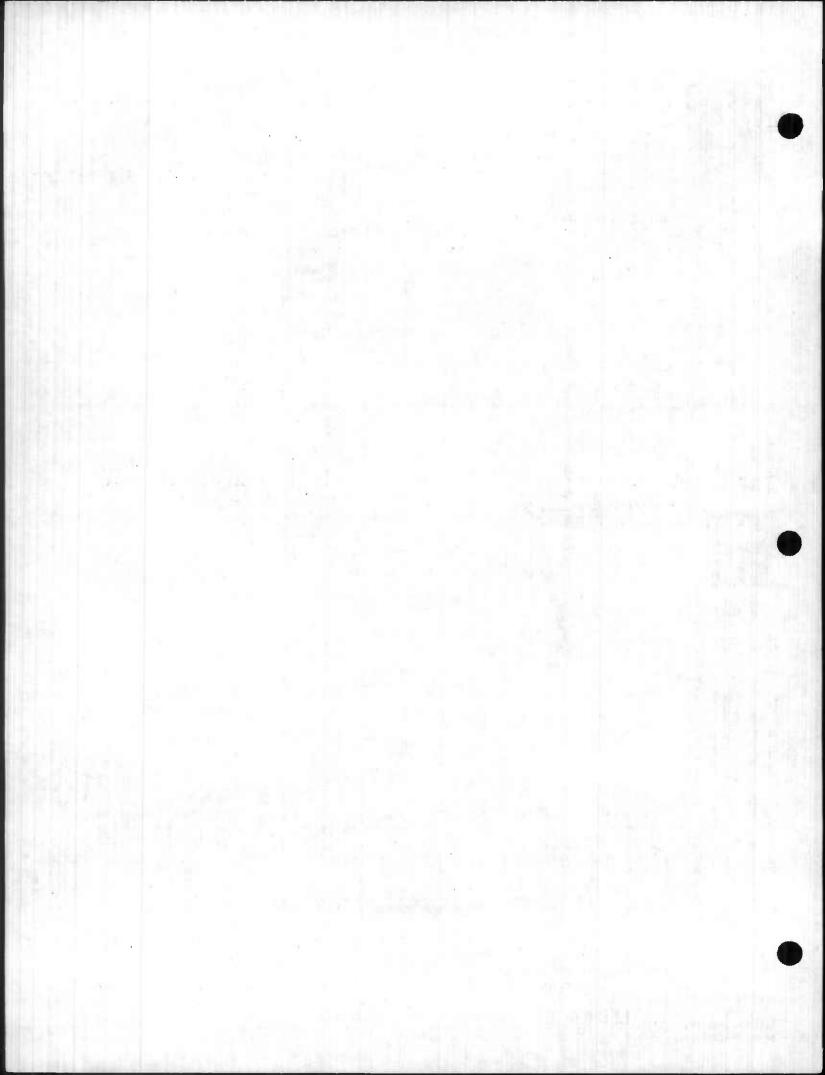
28e. Pleca of lojury - At home, ferm, street, fectory, office building, etc. (Specify)

Tancoll Penn Street, Baltimore, Maryland 21201

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

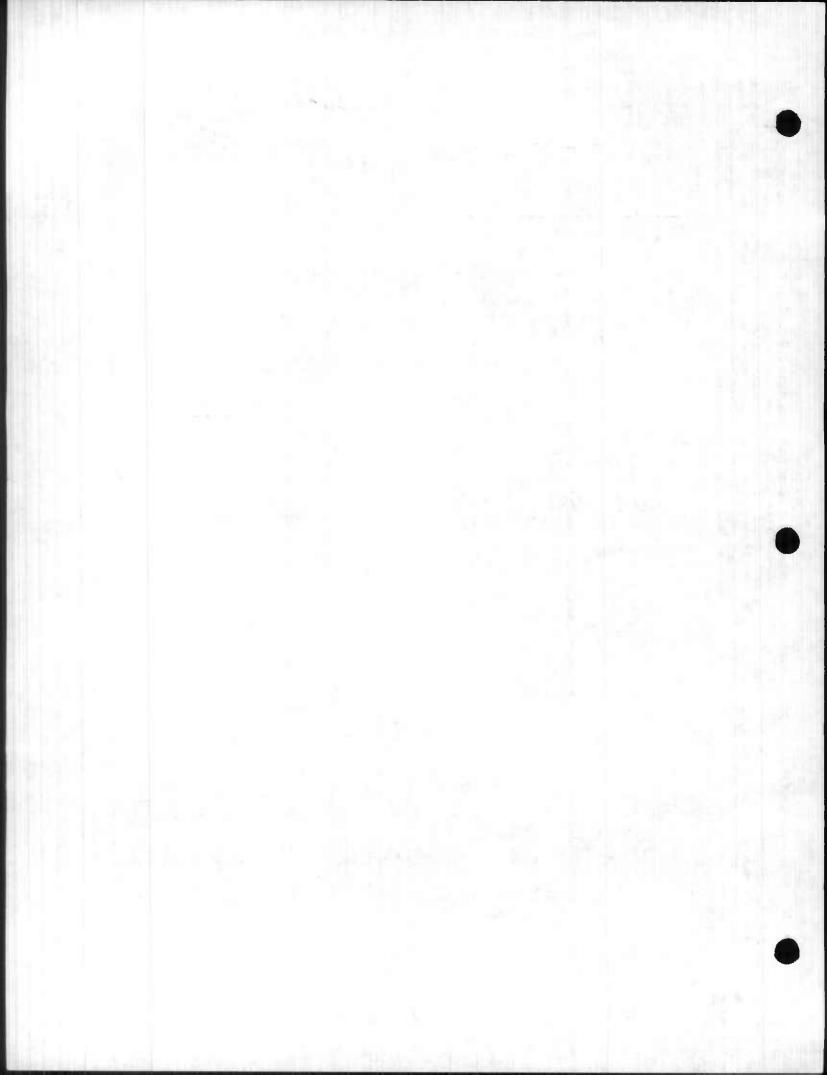
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State of Maryland / Department of Health and Mental Hygiene 0 1, 2756

		Certificate of Death	Reg. No.	12100				
Dhuninian	Decedent's Name (First, Middle, Last)	1	2. Date of Death Month Day Year	3. Time of Death				
Physician /Medical	HUDA	MLLHOHNY	DECEMBER 22 200	1 1 1 1 1 1 1 1 1 1 1				
Examiner	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or l	Location of Death 4c. County of Dea	ath				
	Johns Hopkins Hos	pital Baltin	ore City					
uneral Director	5. Social Security Number 6. Sax 1 M 2 M F 66	Ast birthday)  If Under 1 Year  If Under 24 Hrs.  Months  Days  Hours  Min.	_ (Month, Day, Year) _ C	irthplace (Stete or Forei Coughy) gland				
3	Usual Residence of Decedent  10a. State 10b. County 10c. Cit	y, Town or Location		10d. Inside City Limi				
or and	Virginia Arlington	Arlington		1□ Yes 2□N				
be notified be notified Director	10e. Street and Number	10f. Zip Code	10g. Cifizen of What C	^				
23a or	900 N. Stuart St.#716	22203	London	don, England				
al, or Itams 23a or 28a-f show Examiner must be notified at by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U. Armed Forces?  1 Yes, Give Year or Dates:	.S. 13. Was Dacedent of Hispanic Origin? (S If Yas, specify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)  14. Race - Am Black, Wh Specify: W	nite, etc.				
ygiene. Ner than "natural", It, the Modical Ear. Completed by	15. Decedent's Education (Specify only highast grade completed)	16a. Decedent's Usual Occupation	16b. Kind of Business	s/Industry				
nple	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of world life. DO NOT use retired)						
Hygiene. other than and, me is e Comp	4	Homemaker	Home					
nd Mentel Hygiene. merked other than imatic avant, tra M To Be Comp	17. Fathar's Nama (First, Middla, Last)		me (First, Middle, Maiden Sumame)					
Mentel priced o attic avi	Victor Henry Cooper	Flore	nce Allen					
E E	19a. Informant's Name/Relationship (Type, Print)	19b. Malling Address (Street end Number or Ru						
item 27 i	Gaafar Allagany- Husband	900 N. Stuart St.#7						
5 = 5	1 StBuriel 2 Cremetion 3 DRemovel from State	Place of Disposition (Neme of semelery, cremetory or other plece) ational Memo. Park	20c. Location - City of 12-23-2000 Fall:					
Department Important: I any injury o	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Un:	iversal II Morti	uary Inc.				
	23a. Part1. Enter the disease, or complications that caused the daat shock, or heart failure. List only one cause on each line.	n. Do not enter the mode of dying, such as cardia-	or respiratory arrest,	Approximate				
ysician	Shook, or heart lander. List only one souss of each line.			Interval Between Onset and Death				
Medical	Immediate Cause (Final disease or condition INTRA CR	LANIAZ HEMORKHAG	E	24 HOUR				
aminer	resulting in death)	or as a consequence of):						
i e								
physicien and s the burial-transit edical Examiner	Sequentially list conditions,	or as a consequence of):						
	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury							
physicients the burner of the		r as a consequance of):						
0 6	d							
or us								
d by the attending letached for use a Physician/M	Part II. Other algnificant conditions contributing to death but not res	ulting in the underlying cause given in Part I.	23b. Did tobacco uee contribu	ite to the cause of de				
signed by the attendired be detached for use detached for use detached for by	PNEUMOCYSTIS CARINII	PNEUMONIA	1 Yee 2 No 3	Probably 450nkr				
houri houri	PRIMARY CENTRAL NER	UOUS SYSTEM LYMPHON	24a. Was an autopsy performed?	b. Were autopsy findin available prior to completion of cause of death?				
pege Con			1 □ Yes 2 □ 16	1 Tyes 2000				
ertific ector,	25. Was cese referred to medical examiner?		ath (Check only one)					
G dire	HOSDITAL:	ER/Outpatient 3 DOA Other: 4 Nursing H	Homa 5 ☐ Residence 6 ☐ Other (Sp	oecify)				
25 (0)	27. Manner of Death 1 Natural 5 □ Pending (Month, Dey Year)	28b. Time of 28c. Injury at Work?	28d. Describe how injury occurred					
oeth.	2 Accident investigation	M 1 Yes 2 No						
rs after deeth.  al Director: After t led in by the funers  Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, factory, office y)	28f. Location (Street end Number or City or Town, Stete)	Rurel Route Number,				
within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)  29 Medical Examiner: On the basis of examina and manner stated.	wledge, death occurred at the time, date and place tion and/or investigation, in my opinion, death occu	a, and due to the cause(s) and manner urred at the time, date and place, and d	as stated. ue to the cause(s)				
Me Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	onth, Dey, Year)				
	MOPOR A MAN	RFS - 000	-					
e	INTLUS IIIOD.		) DECEMBER	77 700				
	30. Name and address of person who completed ceuse of death (Item	* * * * * * * * * * * * * * * * * * * *	00-					
	NANA CEASAR; JOHNS HOP	KINS HOSPITAZ;	BACTIMORC					
State	31. Date filed (Month, Dey, Year)  32. Registrar's Signa	dura 6						



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ida Aal 12-27 - 200004:30A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner FREDERICK FREDERICK COLLEGEVIEW NURSING CENTER If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2₩F Days Hours Months 85 Yrs. 047-16-9950 GERMANY Director 12-12-1915 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. fnside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Mapical Examinar must be notified at M☐ Yes 2☐ No Directo FREDERICK FREDERICK MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21703 USA 1410 ORANGETIP COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Hygiena. POULTRY FARMER POULTRY 8 permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic avent, phose. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be BERTHA BRUECK JOSEF NATHAN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1410 ORANGETIP COURT, FREDERICK, MARYLAND JACK AAL/SON 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State DEC 29 CHEVRA KADISHA OF ALLIANCE 4 ☐ Donation 5 ☐ Other (Specify) 2000 NORMA, NEW JERSEY 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner rangn Due to (or as e consequence of) Examine the deeth certificate be executed physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequenca of) Box 68760. Physician/Medical thal initiated events resulting in death) Last Due to (or as a consequence of): for use as t signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? should I Completed 24a. Was an autopsy performed? irector, page 2 s 1 ☐ Yes 2 ☐ No Be director, 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 axaminer?
1 Yes No

27. Menner of Death
1 Netural
2 Accident Hospital: 2 Nursing Home 5 Residenca 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA Aftar this funeral 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation r death. 1 Yes 2 No octor: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 D Homicide 듑 within 24 hours at To the Funeral Di completely filled in 29a. Cartiful Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. edical 29b. Signature 29c. License number 29d. Date-signed (Month, Day, Year) title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Thurson Dr # 100 Hiren shah

Registrar **DHMH 16 Rev 6/95** 

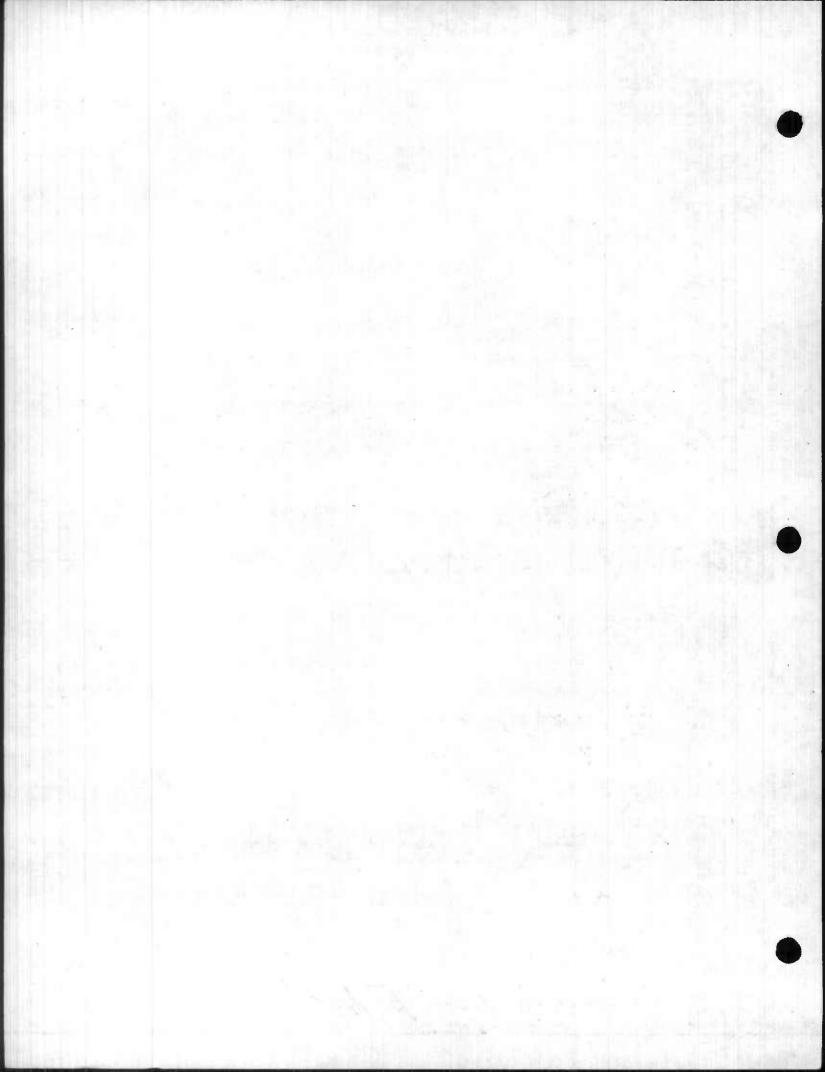
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31. Date filed (Month, Da

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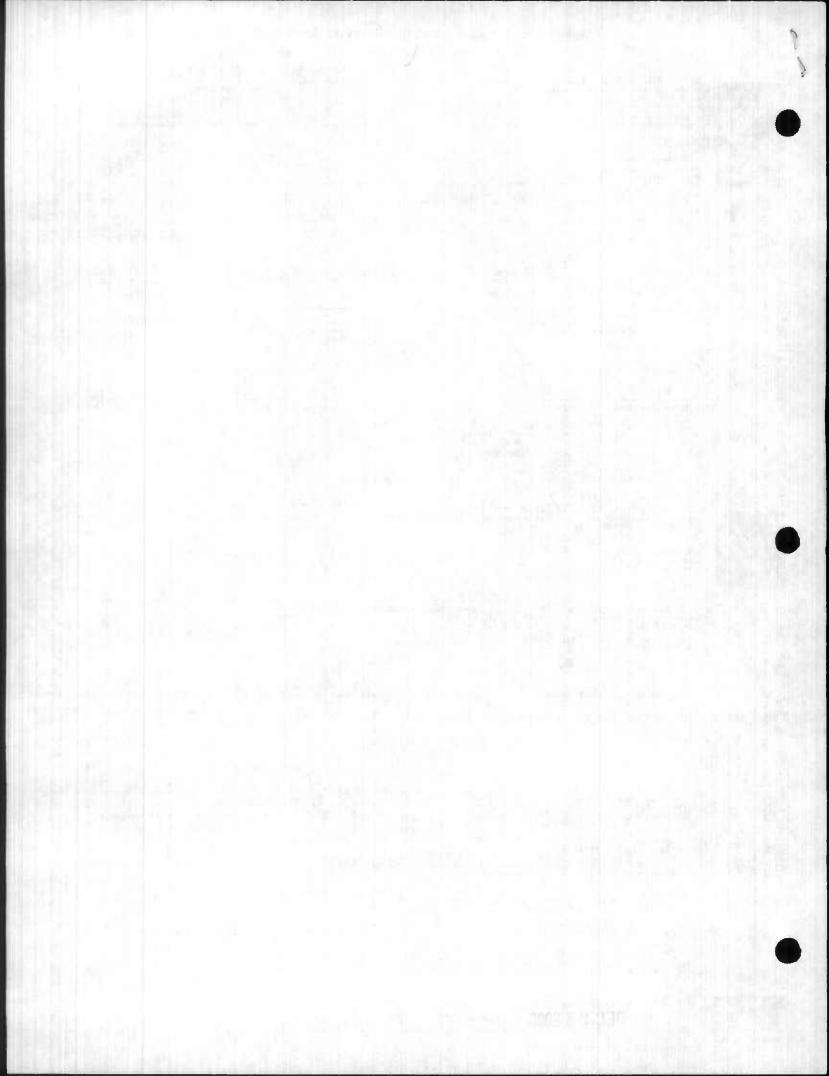
32. Redistrar's Signature



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State of Maryland / Department of Health and Mental Hygiene 0 42758

			C	ertificate	of Death		R	eg. No.	461	00	
Dhusisian	1. Decedent'a Neme (First, Middle, L	ast)					te of Deet	h Dey	Year 3. T	ima of Death	
Physician /Medical	RONALD	BLEVINS						18,200		:20 p	
Examiner	4e Facility Name (If not institution, go		m, or Location	of Deeth	4c. County	of Death					
	5118 Teeter Ro		town			11 Coun					
Funeral Director	5. Social Security Number 6. 219–68–8931  Usuel Residence of Decedent	Sex 7. Age (In )	rs. last birthde	Montha	Year If Under 2 Deys Hours	Min. (M	te of Birth onth, Day, ne 22	Year) 2,1957	9. Birthplece ( Country) Maryla	-	
ž	10a. Stete 10b. County	10c.	City, Town or	Location					10d. In:	side City Lim	
or 28a-f sho be notified a Director	-	1 County			Taneyto	own				Yes 2 🟋	
	10e. Street and Number 5118 Teeter Roa	ad		10f. Zip (	21787		10g. Citizen of What Country? United States				
by F		12. Was Dacedent Ever in Armed Forcas?  1  Yes 2 No If Yes, Give Yeer or Detes:	1 U,S. 1	3. Wes Decede If Yes, specif 1 Yes 2	nt of Hispanic Original Cuban, Mexicen, No Specify:	In? (Specify Yo Puerto Rican,	es or No- etc.)	Bled	ce - American Inc ck, White, atc. white	lian,	
ygione. ner than "matur rt, the Medical Completed	15. Decedent's E (Specify only highest g		16a. De	cedent's Usuel	Occupation	of working		16b. Kind of Bu	usiness/Industry		
Man old	Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use	done during most retired)	or working					
Con the		1	su	rveyor-	draftsmar	1		draft	ing		
d oth	17. Father's Name (First, Middle, Las	17. Father's Name (First, Middle, Last)  18. Mother's Neme (Fi									
Month artice affice To F	William Lundy	adys An	derso	on							
Dun and	19a. Informant's Name/Ralationship	(Type, Print)			Street and Numbe	r or Rural Rout	e Number	, City or Town,			
er tr	Tammy L. Blevins			3 Teete		Tane		n, Mary		1787	
ont of He It: If Berry y or oth	20e. Method of Disposition  1 Subtrial 2 Cremation 3  4 Donation 5 Other (Special Control of Contro	DRemovel from State	cemetery, c	position (Name ramatory or oth Church	e of ner place) 1 Cemeter	Dec	21		City or Town, S		
d by the attending physician and let compared for use as the burial-transit and let compared for use as the Examiner Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in deeth) Last	a. ELECTRIC Dua to BLEEDIA Due to C. METASTA Due to	AL Moore of the constant of th	ECHAV sequence of): sequence of): ANLRE sequence of):	ATIC C	ardiac or resp	AT/ 0	est,	Apprinter Onse	NTHS	
y the sched	Part II. Other significant conditions	contributing to death but not	rasulting in the	sulting In the undarlying cause given in Part I.					ontribute to the		
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sate has been signed by the spage 2 should be detached.						2	4a. Was e perfor	n eutopsy med?	24b. Were eu eveilable completi of deeth	prior to	
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e de O	25. Was casa referred to medicel				26. Place	of Death (Che	ck only on				
rior, pag		Hospitel:	□ ER/Outpet	ient 3 DO/	Other:			ence 6 Oth	ner (Specify)		
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10 mel

Registrar

M.D. 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

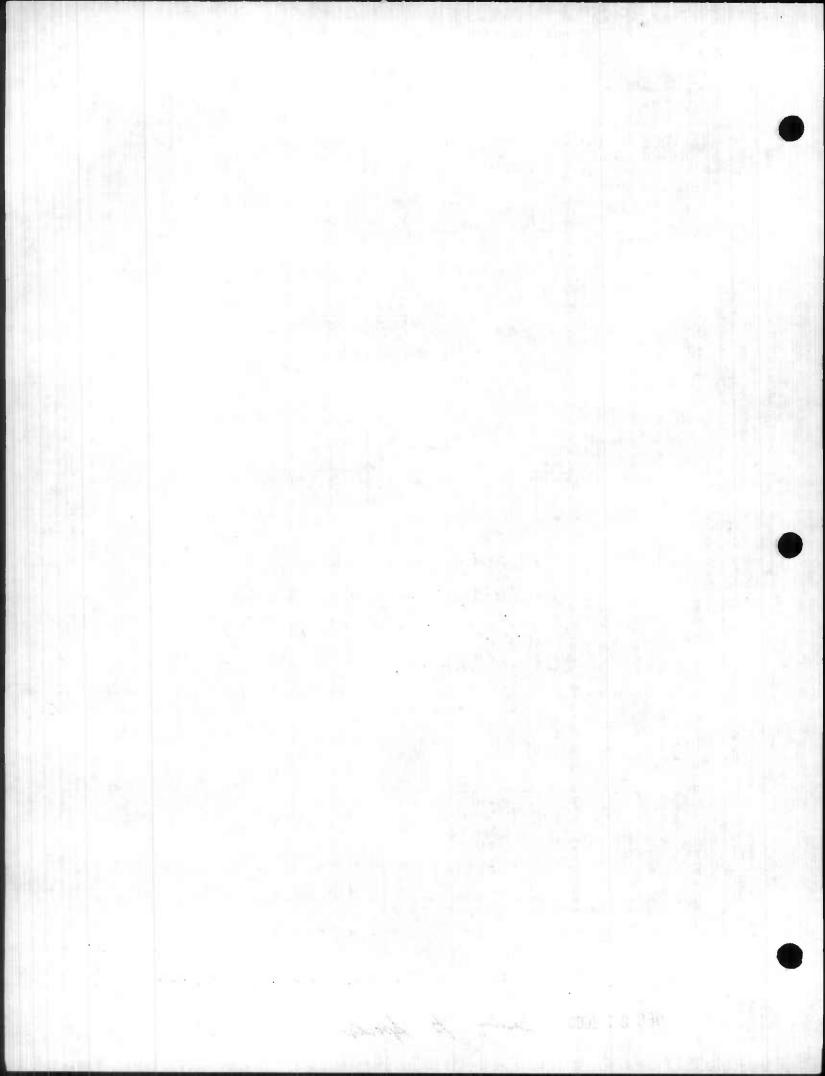
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December 26,2000

31. Dete filed (Month, Dey, Year) State

2000

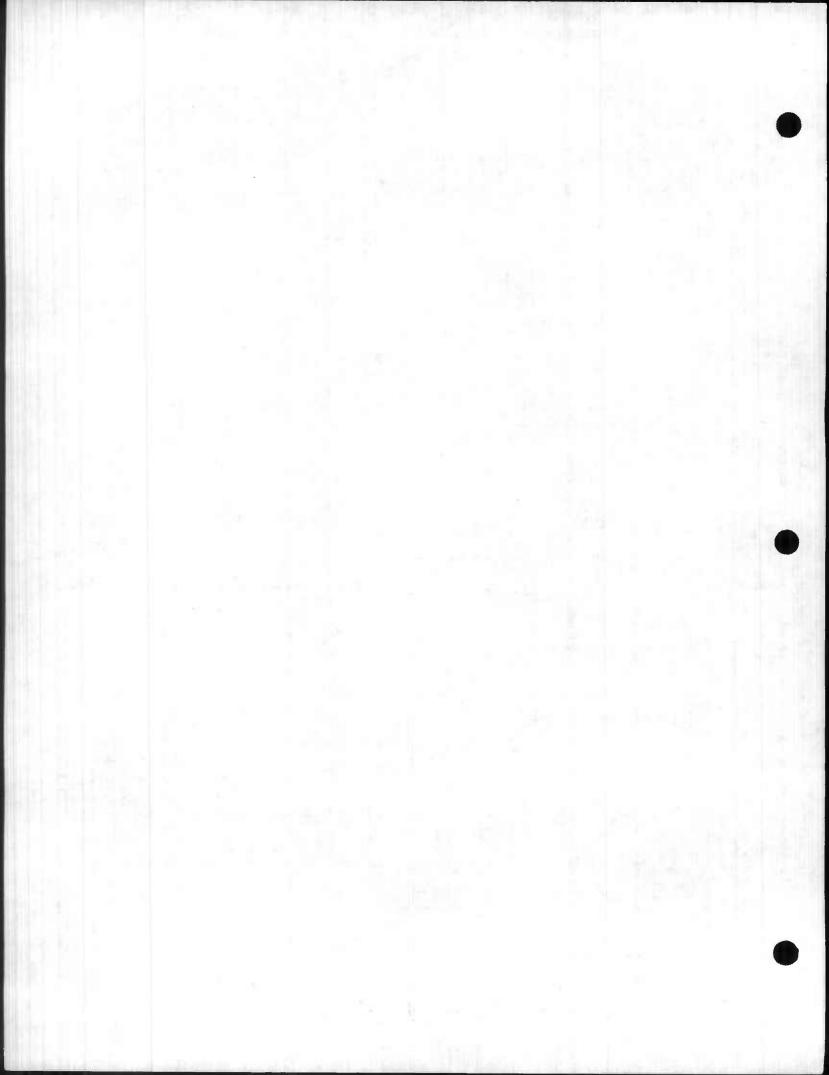
32. Registrer's Signeture ORIGINAL



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 42750

									Death			Reg. No.				
	1. De	cedent's Nama (First, Middle	a, Last)		5.80	16.7					2. Data of De		Yae	or	3. Time of Deat	
Physician /Medical	Ma	ttie L. Brei	terman							1	Decemb		, 200		4:45 PI	
Examiner	45 City Town of									wn, or Lo	cation of Deat	h 4c. Co	ounty of D	eath		
	Po	Potomac Valley Nursing Center Rockvill								ille						
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Undar 1 Yaer If Under 24 Hi								8. Date of Birth (Month, Day, Year) 9. Bir			nery Birthpia	ca (Stata or Fore		
Director		5-05-6933	1□ M 2§	ΣF	79	Yrs.	Months	Days	Hours	Min.	December December	8, 192	1	Vir	ca (State or Ford y) ginia	
3_	Usual Rasidenca of Decedant  10a. Stete 10b. County 10c. City, Town or Location													100	d. Inside City Lin	
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or 28a-f s Le notified Director	10a. 5	Street and Number					10t. Zi	p Coda				10g. Citiza	n of What	Countr	у?	
23.8	12	35 Potomac Va	alley R	load			20	850					ted S			
or items 23a or 28a-f show miner must be notified as Funeral Director	11. M	arital Status	12. Was	s Decedent	t Ever in U,5	S. 13.	Was Dece	dant of h	lispanic Ori	gin? (Spo	ecify Yas or No Rican, atc.)	0- 14	. Race - A Bleck, W			
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To the Hospital of within 24 hours af To the Funeral Di completely filled in

29b. Signature and title of certifier

MD.

29c. License number

29d. Date signed (Month, Day, Year) December 28, 2000

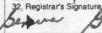
11/2/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> 111 Penn Street, Baltimore, Maryland 21201 dentz

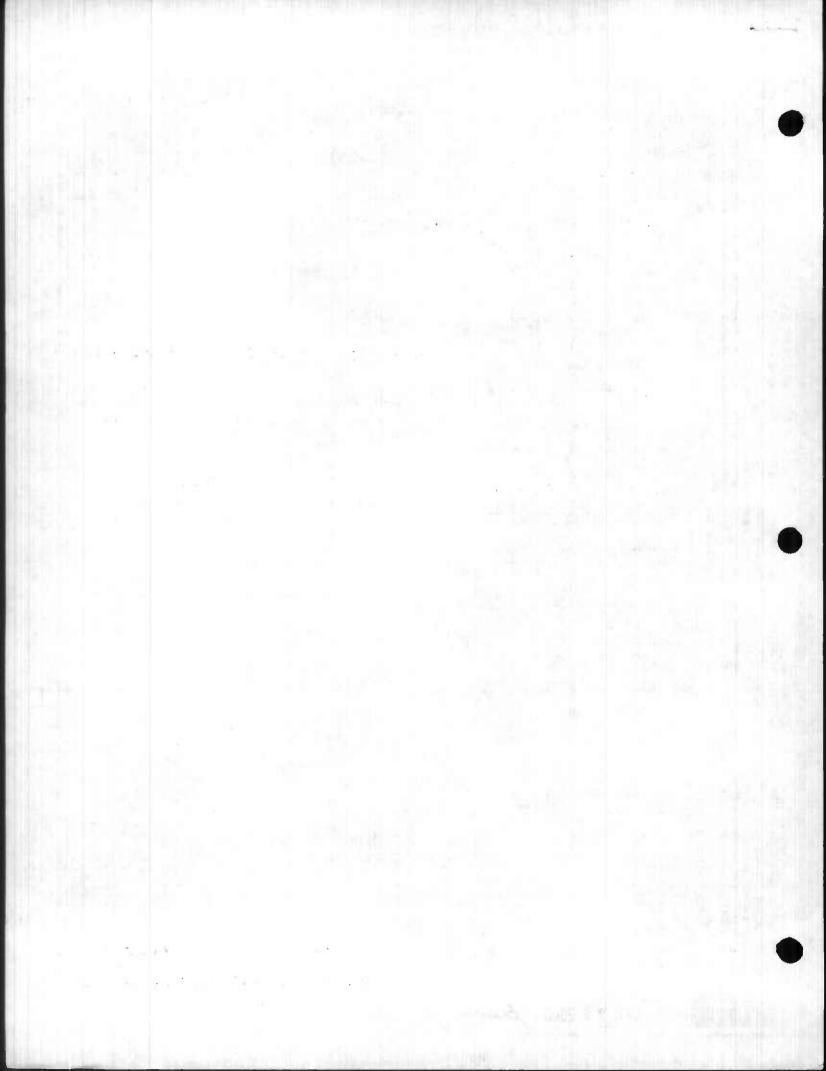
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State Registrar 31. Date filed (Month, Day, Year) DEC 2 9 2000

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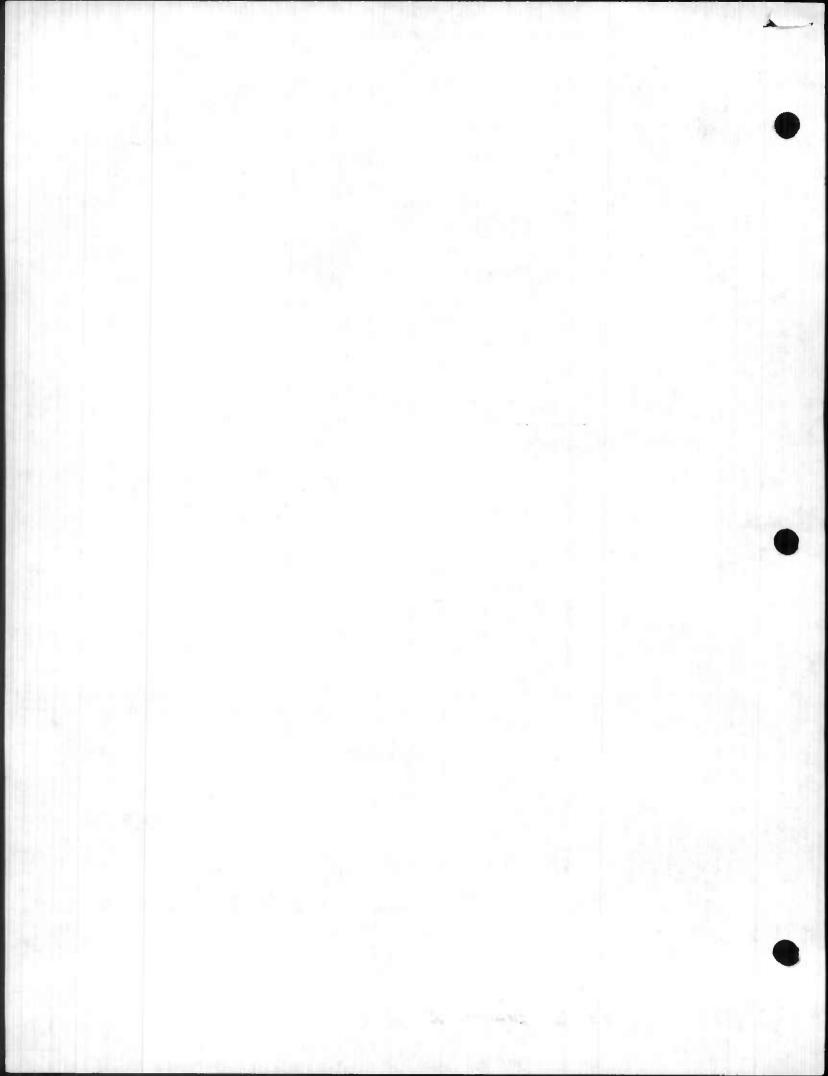


souls



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend #19a	,1/2/2001,BMW,Monto	State of Mary		ertificate of			Reg. No.	42762		
Physician	1. Decedent's Name (First, Middle, La					2. Dete of De Month	Day	3. Time of Death		
/Medical	Rail J. Bely				4b. City, Town, or I	Decembe				
Examiner	4a Facility Neme (If not institution, giver 14107 Manorvale F									
	5. Social Security Number 6. S		yrs. last birthde	If Under 1 Year	Rockvil If Under 24 Hrs.		Montgomery of Birth 9. Birthplece (5			
Funeral Director		K) M OFF	75 Yrs.	Months Deys	Hours Min.	(Month, De	7. Year)	9. Birthplece (State or Fore Country) Vashington, D.		
	Usuel Residence of Decedent				1	TOCCODE!	3, 1525	doning con, D.		
how	10a. State 10b. County	100	c. City, Town or	Location				10d. Inside City Lim		
e Ma	Maryland Montgome	ery	Rockvil	le			. 02 1	1 ☐ Yes 2 🖾 N		
vith the Mar or 28s-f a be notified	10e. Street and Number			10f. Zip Code		2577	10g. Citizen of Wi	het Country?		
eth w		ad			0853			States		
within 72 hours after death with the Maryland of the "natural", or items 23s or 28s-f show he Medical Examinar must be notified a property or property of Funeral Director		12. Wes Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: ₩		3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No		pecify Yes or No o Rican, etc.)	Bleck	- American Indian, c, White, etc. White		
21215-0020 d within 72 hours of piene. The Tretural', or the Tretural of the Model Even	16 Decedent's E			cedent's Usuel Occup	ation		16b. Kind of Bus	singse/Industry		
27275-0 ed within 72 ho ygjene. her than "naturi it, the Medical	15. Decedent's Ed (Specify only highest gra	de completed)	during most of word)	king	100. Killd of Bus	aness/modery				
with with the the	Elementery/Secondery (0-12)	Cotlege (1-4or 5+) 4		Controlle			Construc	ction Company		
Hyging C						ne (First, Middle,	Maiden Sumame			
ire, Maryland 212.  I and 2 should be filed within fleath and Mertel Hygiere.  Item 27 is marked other than other treumstic event, the H	Henry D. Berg, Si				Mary Co	rrell				
should Municipal Management	19a. Informant's Neme/Reletionship (	State, Zip Code)								
end 2 earth er treu	Jane P. Berg/Daug		1410	7 Manorva	le Road,	Rockvi1	le, Mary	land 20853		
BAITIMOTE, IN Demit. Peges 1 end Department of Health Important: If Item 27 any Injury or other tr once.	20e. Method of Disposition		0b. Plece of Dis	position (Name of	ce) T	Dete		City or Town, State		
Peges nent of I	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	iel 2 Cremetion 3 Removal from State Gate of Heaven Cemetery 30,2000 Marylan								
Daltimo permit. Pege Department of important: if any injury or once.	21. Signature of Funeral Service Licer			22. Name end Addre	ss of Fecility Ro	pert A.	Pumphrey	Funeral Hom		
Depart Permitter	> VH /4	M					ry Avenue,			
	23a. Part1. Enter the diseesing comshock, or heart failure.	tions that caused the		Rockville, enter the mode of dying				Approximete		
Physician	shock, or heart failure. List only	tine ceuse on each line.						Interval Between Onset and Death		
/Medical	Immediate Cause (Final disease or condition	Mvoca	rdial I	nfarction				5 Minutes		
Examiner	resulting in death)	e								
P = 5		Coron	ary Art	ery Diseas	se			400		
OX OS/OU, certificate be assecuted ding physician and se as the burial-transit	Sequentially list conditions,  Due to (or es e consequence of):									
nat the death certificate be by the attending physicis letached for use as the but Physician/Medical	thet initieted events resulting in death) Last	Due	to (or es e cons	equence of):						
attending p		d.								
d - 5 - 5										
the de	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the	underlying cause give	ven in Part I.			tribute to the cause of dea		
that the death edby the atte detached for Physicia	Hypertension					10	Yes 2 No	3 Probably 4 Unkn		
aw requires to be sign 2 should be 2 should be 50 should							an autopsy med?	24b. Were autopsy finding available prior to completion of cause of death?		
						10	Yes 2 No	1 ☐ Yes 2 ☐ No		
ysician: The ysician The sis certificate director, pag	25. Was case referred to medical				26. Place of Dec	eth (Check only	one)			
- K		Hospitel: 1 ☐ Inpatient	2 ER/Outpat	ient 3 DOA	her: 4 Nursing H	lome 5⊠ Resi	dence 6 □Othe	r (Specify)		
After fune			ar) 28b. Time	y Wo	ry et rk? ∣Yes 2 □ No	28d. Describe	how injury occurre	bd		
To the Hospital or Attending P Within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Plece of Injury - building, etc. (S	At home, farm, pecify)	street, factory, office		28f. Location ( City or To	Street end Numbe vn, State)	er or Rurel Route Number,		
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certiff		ysician: To the best of my niner: On the basis of exa and manner stated.	minetion end/or							
To th Comp				29c. Licens				(Month, Dey, Year)		
20,	1 porto	an		I	21340	I	ecember	27, 2000		
+	30. Neme and address of person who	completed ceuse of deeth	(Item 23a) (Typ	e, Print)	33-211					
	Raymond A. Bass, N	I.D. 3941 F	errara l	Drive, Whe	aton, Ma	ryland 2	20906			
State	31. Date filed (Month, Dey, Year)	32. Registrar's		1				5.4		
Registrar	DEC 2 9 2000	Denva	Ø.	Sporker						



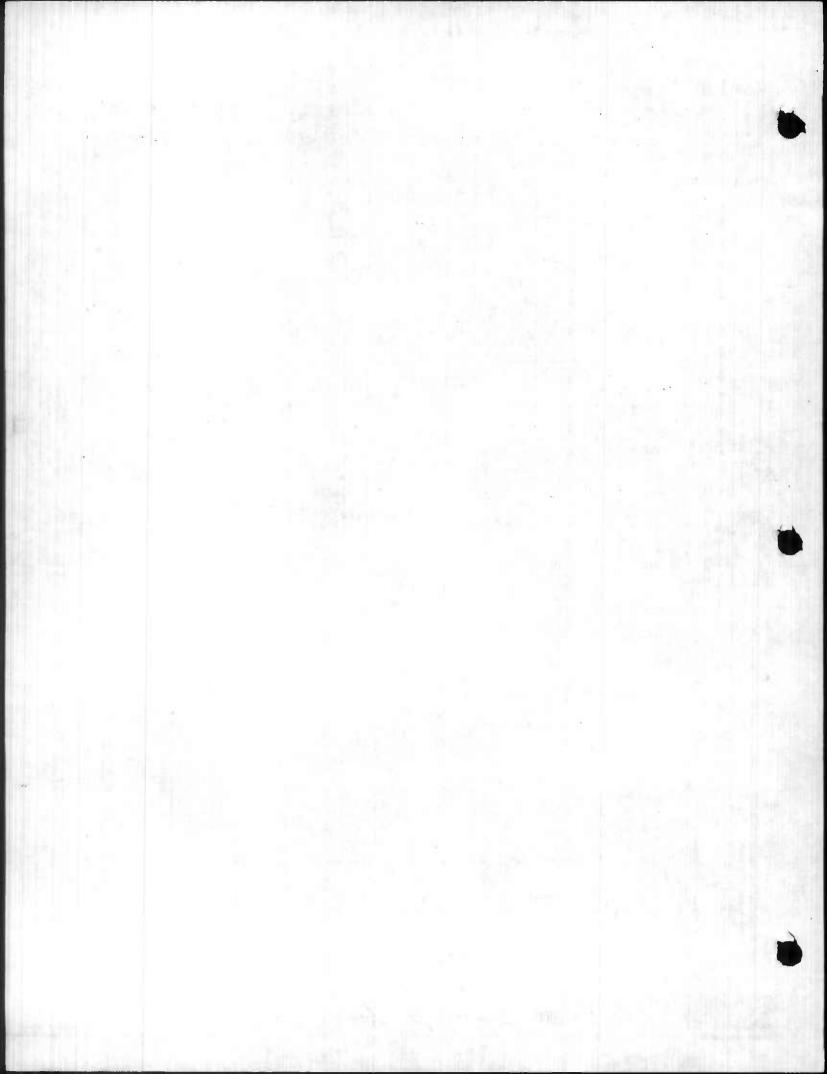
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Physic	ian	1. Decedent's Nama (First, Middla,	Last)	2. Data of De Month	Day	Year	3. Tima of Death						
/Medi		Theresa Marie B	asko						ber 26,		5:15pm		
Exami	ner	4a Facility Nama (If not institution,	giva street and no	ımber)		4.015	4b. City, Town,	or Location of Deat	h 4c. Count	4c. County of Death			
		SHADY GROVE	ADVEN	TIST HO			ROCKV			GOMEF			
Funeral		5. Social Security Number	Sex	7. Aga (In yrs.		Indar 1 Yaar	If Undar 24 H	Irs. 8. Data of Bil	rth av. Year)	9. Birthple	aca (Stata or Foraign ry)		
Director		114-38-5432	1□M 2⊠F	89		20,0		Dec. 5	, 1911	Penns	ÿlvania		
2		Usual Rasidenca of Decedant											
E Po		10a. Stata 10b. County		10c. City	y, Town or Location	n				10	d. Inside City Limits		
	cto	Maryland Montg	omery	Gar	ithersbur	g			1 ☑ Yas 2 ☐ No				
natural, or Name 23a or 28a-f show dital Examinar must be notified at	Directo	10e. Street and Number			10	of. Zip Code			10g. Citizen of	What Count	ry?		
23a		452 Girard Stre	et #304			20877	7	1-3	United	ited States			
natural, or hems 23a or 28a-f show	Funeral	11. Marital Status	12. Was Dec	Was Decedent Ever in U,S.  13. Was Decedent of Hispanic Origin? (S Armed Forcas?  14. Was Decedent of Hispanic Origin? (S If Yas, specify Cuban, Mexican, Puert					o- 14. Ra	ce - Amarica	n Indian,		
5 8	Ē	1 Nevar Married 2 Marrie	d 1 ☐ Yas	2 🖾 No				eno Hican, atc.)		Black, Whita, atc.			
5.0	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, G Yaar or I	iva Datas:	104	as 2N No	Specify:		Speci	Specify:			
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u 0	ple	(Specify only highest Elemantary/Secondary (0-12)		(1-4or 5+)				working					
. the	E	12	Conogo	(1-401 54)						Own Home			
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		Eleanor Candaffi	o (Daugh	tor)	452 Gir	19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State 452 Girard Street #304 Gaithersburg, M							
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important: If any injury or ance.		4 Donation 5 Other (Spe		Met		opolitan Crematory  12/27/00 Alexandria, Virgin							
Important: I any injury o		21. Signature of Funaral Sarvice Licensee  22. Nama and Addrass of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877  23a. Partl. Satar tha disease or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Interval Onset at											
2529													
ysician													
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State Registrar

31. Data filed (Month, Day, Year) DEC 2 9 2000

David Klein, M.D.

9901 Medical Center Drive, Rockville, MD 20850 32 Registrar's Signatura parks



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Year 22 Baker 2000 0310 Dec. Henry 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) Months Days 1 X M 2 □ F Yrs. 213-05-1902 94 Nov. 05 1906 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. insida City Limits 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 United States 10400 Grandin Road 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 No Specify: 3 Widowad 4 □ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Dept. of the Navy 8 Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnema) Kruhm Wossowski Emma Jane Lewis August 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) 702 Fairway Drive, Towson, MD Stephen M. Anderson/ POA Date 23 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dec. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory Inc 2000 Beltsville, MD 22. Name and Address of Facility Rapp Funeral Stephen D. Lohrmann, PA, 933 21. Signature of Funeral Sarvice Licenses Cremation Serv. Stephen D. Lohrmann, Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that the flad the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Approximata Interval Between Onset and Death ( and to Senic Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last ORONARY

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Directo

Funeral

þ

Completed

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Mapical Examinar must be notified as

permit. Peges 1 and 2 should be filed within 72 hours efter death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23 any Injury or other traumatic event, it is Mexical Examinational Injury.

Baltimore, Maryland 21215-0020

the Marylend

physician end s the burial-transit 80 attending USB ŏ the been signed by 2 certificate hes After this funeral

that the death certificate be executed

The lew requires

or Attending Physician:

Hospital

2 0

deeth.

within 24 hours efter deet To the Funeral Director:

filled in by

edicai

Box 68760.

P.O.

Division of Vital Records,

Examiner Physician/Medical þ Completed Be 2 Certification:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the ceuse of death? 2 No 3 Probably 4 Unknown 1 Yes

24b. Wera autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed?

25. Was cese referred to medical		26. Plece of Death (Check only one)										
examiner? 1 ☐ Yes 2 XNo	Hospital: 1 Inpatient 2 ☐ ER/Out	tpatient 3 DOA Other: 4	□ Nursing Home 5 □ Residence 6 □Other (Specify)									
27. Manner of Deeth  1 Neturel 5 Pending investigation			28d. Describe how injury occurred									
3 Suicide 6 Could not be determined	28e. Plece of Injury - At home, fai	rm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)									

PRINCE

Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

290. Signature a 29c. Licansa number 29d. Data signad (Month, Dey, Year)

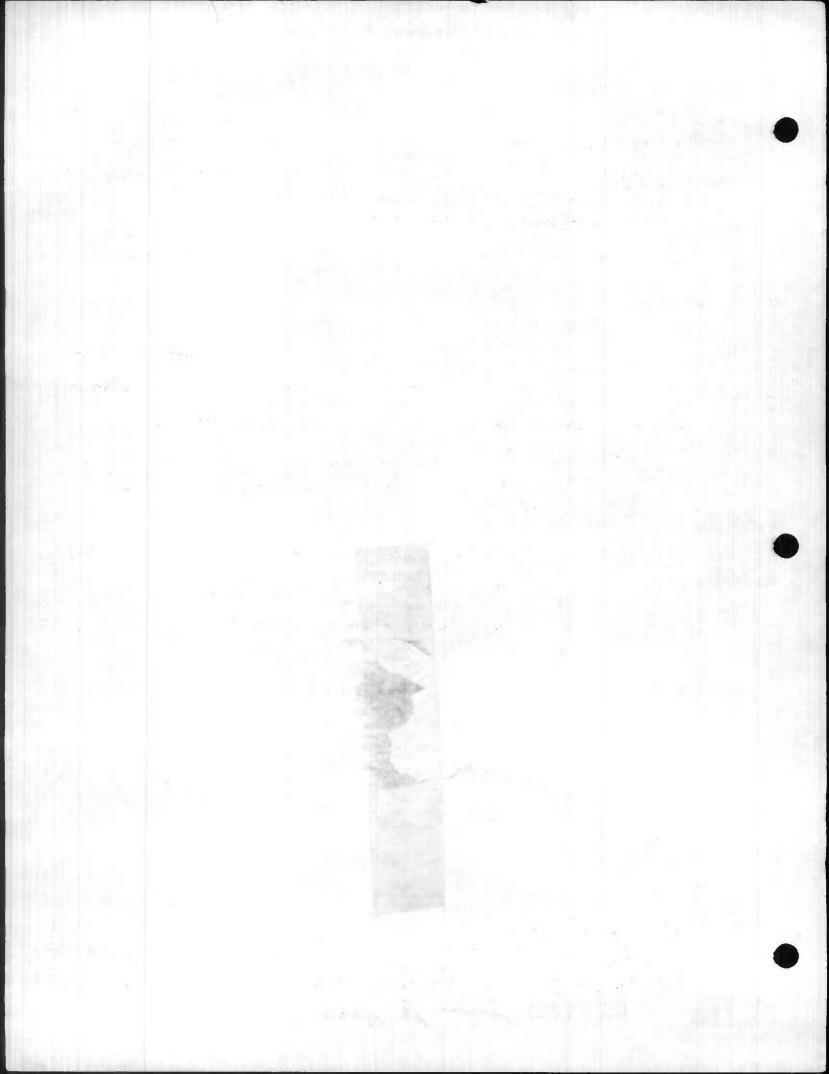
leted cause of death (Item 23a) (Type, Print)

Pegistrar's Signature

iciro

prive Olney Mary

State Registrar



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

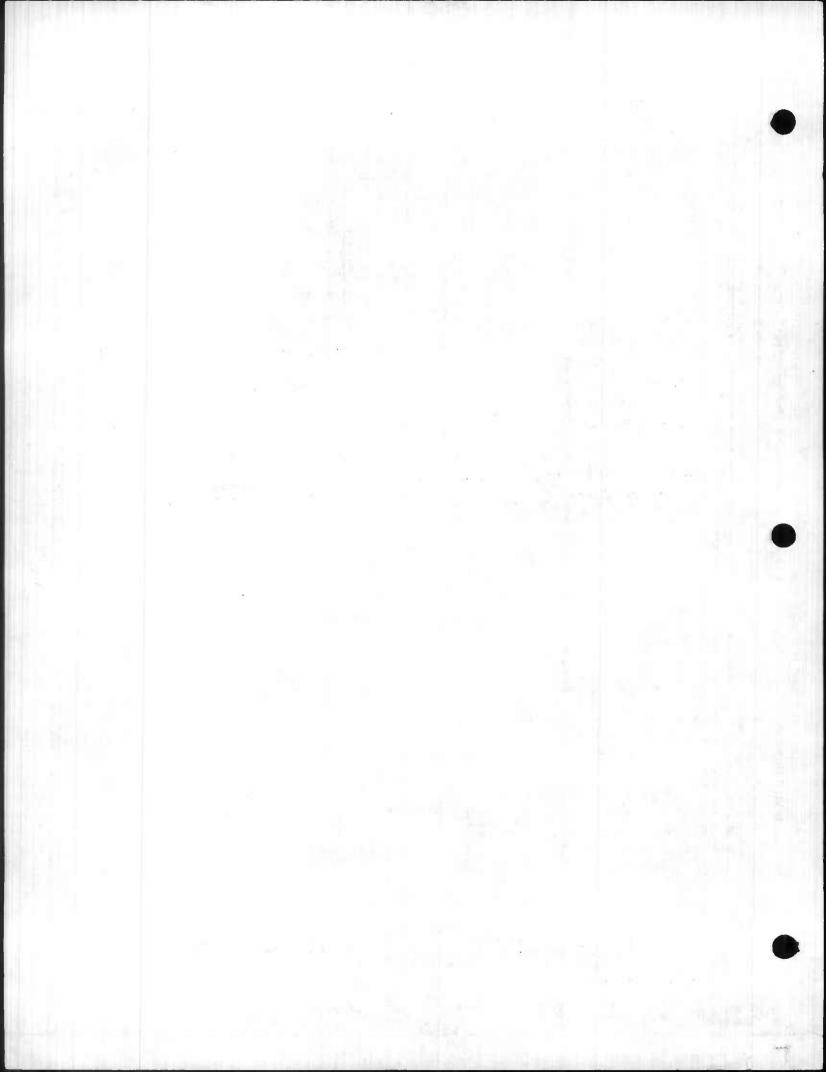
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** MADALINE CARUSO 4:55 PM 26, 2000 December /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4194 Columbia Park Road Pomfret If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 D M 85 Yrs. Director OCT 9 1915 010-10-7705 Usual Rasidence of Decedent Massachusetts 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28a-f show Examiner must be notified at 1 Yes No Director Maryland Charles Pomfret 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4194 Columbia Park Road Funeral 20675 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes ② No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 72 hours after 1 Nevar Merried 2 Married altimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hx Independent of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature any injury or other traumatic event, the Medical pages. Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cleaning Services Domestic 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Sebastian LaRosa 2 Josephine Unknown LaRosa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 4194 Columbia Park Road Pomfret, MD 20675
Date 20c. Location - City or Town, State Joseph R. Caruso (son) 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition

1XI Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) St Michales Cem. -2-01Avon, Massachusetts of Fift 22. Name and Address of Fecility M00173 Eberwein Funeral Services ### Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, lock, or heart failure. List only one cause on each line. 4433 White Plains Lane White Pls., MD 20695 Approximate Interval Between Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical monly Pancreatic Cancer Examiner Due to (or as a consequenca of) Examiner The law requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by 1 Yes 2 No 3 Probably 4 Unknown Records. 2 ate has been signated bage 2 should b 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 20 No certificate Vital Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home \$\infty \text{Residence} 6 Other (Specify) Medical Certification: To 1 ☐ Yes XXXVo 1 | Inpatient 2 | ER/Outpatient 3 | DOA Division of this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After XXXVatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, Stata) 28e. Placa of Injury - Al home, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Di completely filled in XXXCertifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to tha cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) December 27, 2000 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Amir Alikhani, MD., P.O. Box 1890, La Plata, MD 20646 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 9 2000

**DHMH 16 Rev 6/95** 

Registrar



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienen

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ \(\) Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Dey **Physician** December 24,2000 0115 a.m Judith Ellen Creegan /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, giva street and number) 4c. County of Death Examiner Cumberland Sacred Heart Hospital Allegany

9. Birthplace (State or Foreign Country) If Undar 1 Yaar 6. Sex 1 M X F 7. Age (In yrs. last birthday) 5. Social Security Number 8. Dete of Birth (Month, Day, Year) **Funeral** Days Yrs Director June 14, 1942 Maryland 213-40-2849 Usual Residence of Decedent with the Marylend 10e. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Yos 2 No Directo Allegany Cumberland Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 528 Columbia Ave., 21502 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - Amarican Indian, Black, White, etc. 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 11 Maritel Status 72 hours after 1 Yes 3 No If Yes, Give Yeer or Datas: 1 Never Merried 2 Merried permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mentel Hygiene. Introcremt: If itsm 27 is marked other than "natural", or I any Injury or other traumatic event, the internal of page. 1 Yas X No Specify: Specify: P 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grada completed) Elementery/Secondery (0-12) Cottege (1-4or 5+) Food and Gas Store Sales Clerk 17. Fathar's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surneme) William H. Clayton, Sr. Justina H. (Roby) 19b. Mailing Address (Street and Number or Rural Route Numbar, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Lorri K. Witt / Daughter 17406 Oliver Beltz RD SE, Oldtown, MD 21555 20b. Plece of Disposition (Nema of cemetary, crematory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Smithsburg Crematorium 12/27/00 Smithsburg, Maryland 21. Signature of Funeral Service License 22. Name end Address of Fecility Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502 23a. Pert1. Enter the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Zem Immediata Cause (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examine attending physician end for use as the burial-trensit The lew requires that the death certificate be executed Sequentially list conditions, if eny, laading to immediate cause. Entar Underlying Cause (Disease or injury Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760 that initieted evants resulting in death) Lest Dua to (or as a consequance of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware eutopsy findings available prior to completion of causa of deeth? hes been signed 2 should b 24a. Was en autopsy performed? Completed 25. Wes cese referred to medical examiner? page 2 X No 1 Yes 1 ☐ Yas 2 No After this certificate funeral director, pag Physicien: Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) tnpatient 2□ ER/Outpatient 3□ DOA 10 nours after death.

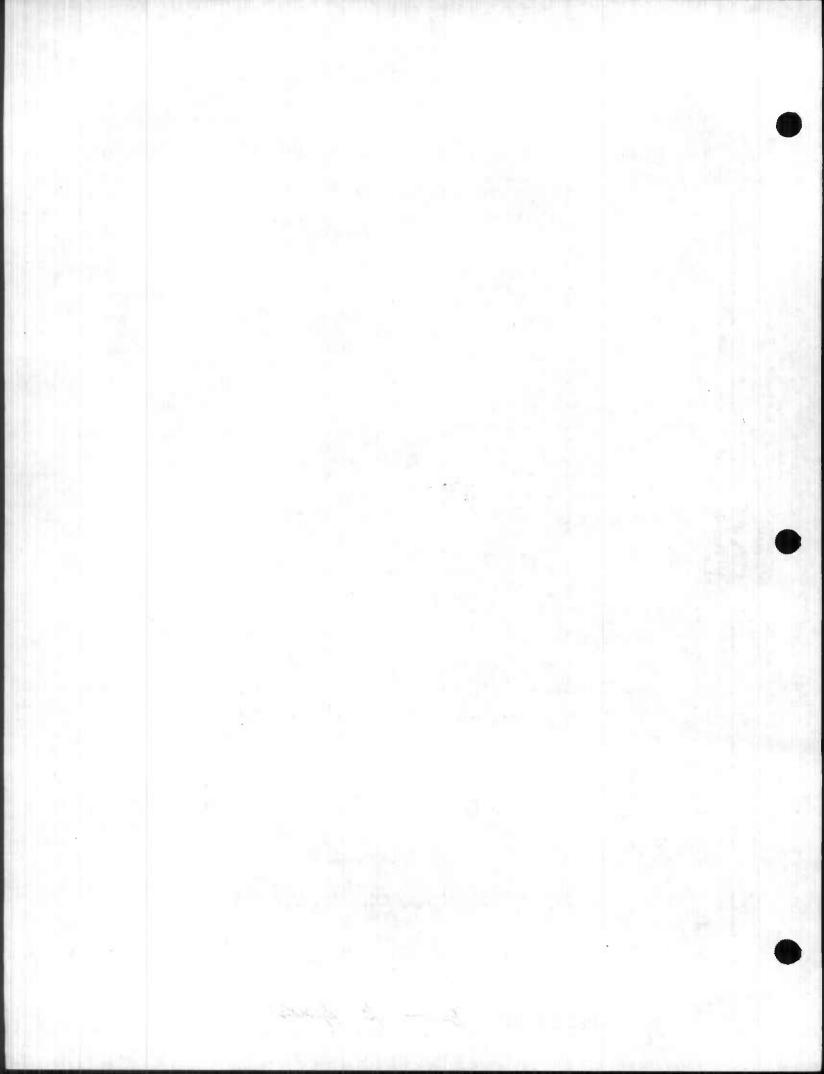
neral Director: After this
filled in by the funeral d 27. Menner of Death To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accidant 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 6 Could not be detarmined 3 ☐ Suicide 28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledga, daath occurred at the tima, dete and ptece, end due to the causa(s) and menner es stated.

I Medical Examiner: On the basis of examination end/or investigation, in my opinion, daath occurred at the time, dete end plece, and dua to the cause(s) and manner stated. edical 29a. Cartifiar (Check only one) 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certifier unaan, M.D. December 2000 ekc 30. Name and address who completed cause of death (Item 23a) (Type, Print) Sacred Heart Hospith, Cumbular Marghed 2,502 SEMAAN,M.D 31. Dete filed (Month, Day, Year) 32. Registrar's Signetura State

DHMH 16 Rev 6/95

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 27,28efp per me G791 1/9/01 yf Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year Month **Physician** Ashton Burt Cobourn November 18, 2000 11:00 pm /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare-Layhill Center Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex 14 M 2□ F Birthplace (State or Foreign Country) **Funeral** 77 Apr 21, 1923 Director Maryland 219-12-4804 Usual Residence of Decedent Maryland 10c. City, Town or Location 10a State 10b. County 10d Inside City Limits Francisco must be notified at 1 Yes 2 No Director Maryland Montgomery Silver Spring the 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 9607 Bristol Avenue 20901 USA Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1ÃI Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritel Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced "netural", be filed within 72 houtal Hyglene.
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Francis J. Collins Funeral Home, Inc. 21. Signature of Funerel Service Licenses 7 Chypeli 500 University Blvd., W, Silver Spring, MD20901 25a. Part I the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, show or hand failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** fmmediate Cause (Final disease or condition resulting in death) /Medical 3 years a. Chronic Lung Disease Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last signed by the attending physician and deeleched for use as the burial-tran Due to (or as e consequence of): Due to (or as a consequence of): Part ff. Other eignificant conditions contributing to death but not resulting in the underlying cause promin to 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Arteriosclerotic Heart Disease by 24b. Were autopsy findings svailable prior to completion of cause of death? 60 should I 24a. Was an autopsy performed? Completed Severe Osteoarthritis with spinal stenosis yr After this certificate has funeral director, pege 2 1 Yes 2 No 1 ☐ Yes 2 ☐XNo macTure Division of Vital Physicien: 25. Was cese referred to medice! examiner? Be 26. Piace of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1K Yes 2 No 10 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28c. fnjury at Work? 5 Pending investigation 1 Watural unknown A 1 Yes 2 No Fell in Nursing Home 9/24/2000 2 X Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Genesis Eldercare Layhill Center Silver Spring, Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide nursing home Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner es stated.

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nerel Director: After the filled in by the funeri within 24 hours at To the Funeral Completely filled I

> 31. Dete filed (Month, Day, Year) State

edicai

29e. Certifier

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) George F. Sengstack

NOV 24

2000

29b. Signature and title of certifier

MD 3929 Ferrara Drive, Wheaton, MD 32. Registrar's Signature

and

29c. License number

D 12121

29d. Dete signed (Month, Day, Year)

November 20, 2000

**DHMH 16 Rev 6/95** 

Registrar

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#### Please Type or Print In Black indelible Ink. Assure Aii Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death **Physician** 10:03AM laire 2 cember 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dev. Yeer) March 8, 1920 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthdey) 9. Birthpleca (Stete or Foreign **Funeral** Deys Hours 1 M 2 E F Massachusetts Yrs. 80 Director 020-14-2150 Usual Residence of Decedent filed within 72 hours after deeth with the Meryland 10c. City, Town or Location 10d. fnside City Limits 10e. Stala 10b. County "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Silver Spring 1 ☐ Yes 2 No Maryland Montgomery Funeral Director 10e. Street and Number 10f, Zip Code 10g. Citizen of Whet Country? United States 20903 10305 Naglee Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indien, Black, Whita, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2X No If Yes, Give Yeer or Detes: 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2√ No Specify: White Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Federal Government Research Microbiologist 5+ 12 17. Fether's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Meiden Sumeme) Peges 1 and 2 should be nent of Health end Mentel int; If New 27 is marked or Esther Kennan Barker William Landers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ste. 435 4301 Connecticut Ave NW Washington, DC 20008 19e. Informent's Neme/Reletionship (Type, Print) permit. Peges 1 and 2 a Department of Health er Important: If Item 27 is eny injury or other trau page. Margaret Haladay / Informant 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stete
4 Donetion 5 Other (Specify) 12/24/00 Brentwood, Maryland Lincoln Crematory 22. Nama and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Suneral Service Licensee 11800 New Hampshire Ave Silver Spring, MD 20904 23a. PetX Enter the disease of a pications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediete Cause (Finel diseese or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner The law requires that the deeth certificate be executed as the burial-transit Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Ceuse (Disease or Injury that initiated evants resulting in death) Last P.O. Box 68760, After this certificate hes been signed by the estending physicien funeral director, page 2 should be detached for use as the buna Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. onspecione Vasculiti, 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Be Completed by 24b. Were autopsy tindings aveilable prior to completion of causa of death? 24a. Was en eutopsy performed? 1 TYAS 2 No 1 ☐ Yes 2 ☐ No al or Attending Physician: The safer death.

I Director: After this certificate of in by the funeral director, pa 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No Medical Certification: To 27. Menger of Death 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Specify) completely filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) end menner stated 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. Licensa number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) charle bowit & 11120

DHMH 16 Rev 6/95

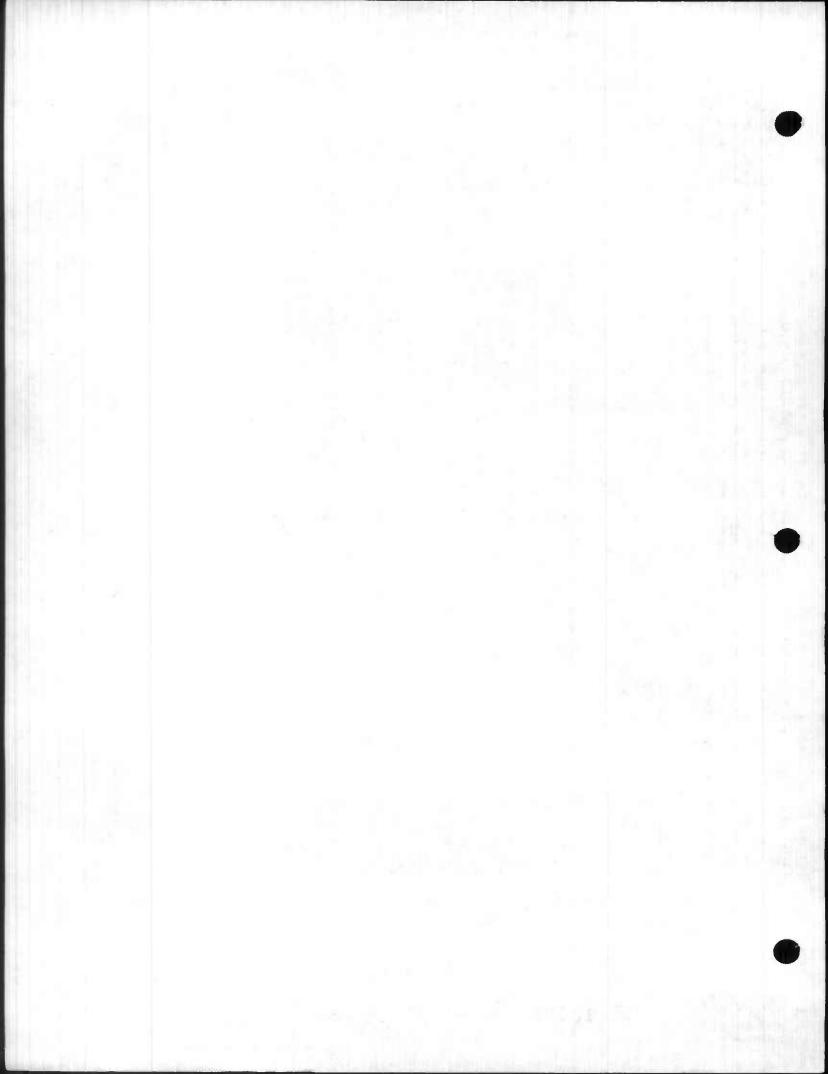
State

Registrar

32. Registrer's Signeture

26

2000



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #1, 12/29/2000, GF, Montgo.Co. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Margaret. Dev Month Yeer **Physician** Maureen -Marie Connelly December 23. 2000 12:45 pm /Medical 4a Facility Name (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death 4611 Kemper Street Rockville Montgomery Birthplace (State or Foreign Country) If Linder 1 Year Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Deys Hours Months 1 □ M 2 X F Yrs 57 Director 219-40-8119 July 9, 1943 Texas Usual Residence of Decedent Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Wedical Exampler must be notified at 1 ☐ Yes 2 No Directo Maryland | Montgomery Rockville 100 10e Street and Number 10f Zin Code 10g. Citizen of What Country? with 4611 Kemper Street USA death Funeral 20853 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 72 hours after 1∑ Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Maryland 21215-0036 1967-1 ☐ Yes 2 ☐XNo Specify: Specify: White P 3 DWidowed 4 □ Divorced 1971 Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, ma the page. Elementery/Secondery (0-12) College (1-4or 5+) 5+ Registered Nurse Health Care 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Lawrence Daniel Sheehy, Sr. Rita Marie Gibbons 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 4611 Kemper Street, Rockville, MD 20853 Date 20c. Location - City or Town, Stete Claire Marie Connelly/ Daughter Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stele 4 ☐ Donetion 5 ☐ Other (Specify) Parklawn Memorial Park 12/27/00 Rockville, MD 22. Name and Address of Fecility Francis J. Collins Funeral Home, Inc. Aral Service License 500 University Blvd., W, Silver Spring, MD 20901 23a Farty Enter the disease, or completations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, about, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical 1/2 years e. Metastatic Breast Cancer Examiner Due to (or es a consequence of): Examiner that the death certificate be executed physician and is the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as e consequence of): 88 980 ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed b þ requires 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an eutopsy performed? page 2 should Completed peen The law this certificate has 1 Yes 2 No 1 ☐ Yes 2X No Physician; 25. Was case referred to medical examiner? funeral director, Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 ☐ Nursing Homa 5 🕅 Residenca 8 ☐ Other (Specify) 2 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Menner of Death 28c. Injury et Work? Certification: 5 Pending investigation 1 (Neture) 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760 P.0. Records, of Vital After t Division Attending s after dea. aj Director: Aftr 6 filled in To the Hospital within 24 hours To the Funeral E completely

10

29b. Signature and title of certifier

3 ☐ Suicide

4 ☐ Homicide

(Check only one)

M.D.

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number D 42452

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end plece, and due to the ceuse(s) end menner steted. 29d. Dete signed (Month, Dey, Year)

Location (Street end Number or Rural Route Number, City or Town, State)

December 26, 2000

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Chitra Rajagopal 18111 Prince Phillip Drive#327, Olney, MD MD

State Registra

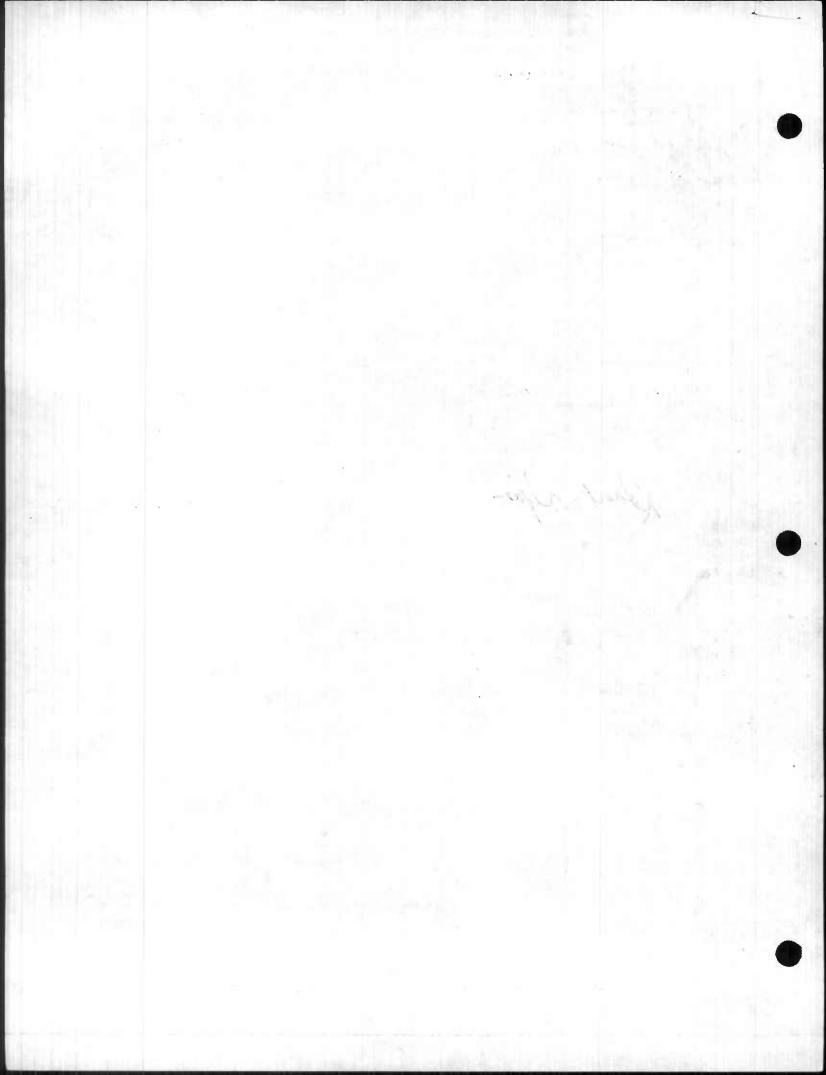
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31. Dete filed (Month, Day, Year) DEC 27 2000

8 Could not be determined

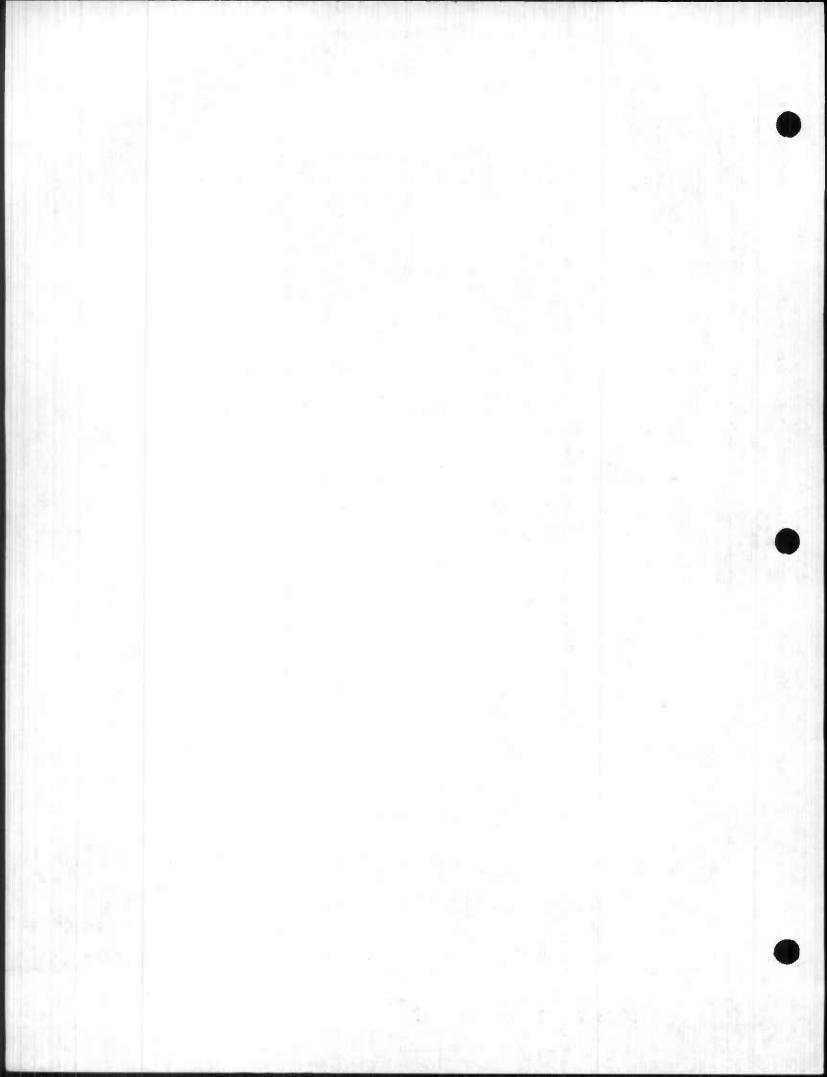
32. Registrer's Signeture

oaks



State of Maryland / Department of Health and Mental Hygiene 1 4 2 7 7 1

All Residence of Decedant  State 10b. County  Aryland Montgome:  Street and Number  311 Pierce Drive  Manital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Educy  Sepecify only highest greet  Sementary/Secondary (0-12)  12  Father's Name (First, Middle, Last)  Enry Hardey Cisse  Informant's Name/Relationship (Ty.  2 gina Cissel / Wi  Method of Disposition  1 Namial 2 Cremation 3 R  4 Donation 5 Other (Specify)  Signature of Funeral Service License  A. Part1. Enter the disease, or complishock, or heart failure. List only or	1, Sr.  street and number)  st Hospital  X 7. Age (in  M 2 F 7. Age (in  TY S  12. Wes Decedent Ever Armed Forces?  1	yrs. last birth. 78 Yr 78 C. City, Town of 11ver In U.S. WII  16a. C	Months  or Location  Spring  10f. 2  20  13. Was Dec  If Yes, sp. 1 Yes  Decedent's Us  Give kind of wife. DO NOT  te Buil  Meiling Addra  2311 Pi  Disposition (No cremetory or cemetory	ref 1 Year s Days  Tip Code  901  edent of Hisecify Cubar 24 No  reflective Anno de use retired, and except and Address S. J.	18. Mother's Nan Bertha V and Number or Ru Drive  e)	ark  8. Data of Birth (Month, Day May 28, May 28,  pecify Yes or No- o Rican, etc.)  king  me (First, Middle, Virginia aral Route Numbe Silver 3 Dete 2/29/00	Day 2 25, 20 4c. County of 4c.	Year 000 3:1. f Death Omery 9. Birthplaca (Ste Country) Maryland 10d. Inside 1 V nat Country?  - American Indian, White, etc. White iness/Industry  ction  Stete, Zip Coda) MD 20901 City or Town, State	e City Lim										
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Aryland Montgome: Street and Number  3311 Pierce Drive Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edur (Specify only highest greds and the status) Elementary/Secondary (0-12) 12 Father's Name (First, Middle, Last) Enry Hardey Cisse a. Informant's Name/Relationship (Ty. 2013) Method of Disposition 1 Method	12. Wes Decedent Ever Armed Forces? 1 □ Wes 2 □ No If Yes, Give Year or Dates: W  Ideation (completed) College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)	WII  16a. C  Hom  19b. Place of C  camerary,  Mt. Zi	Spring  101. 2  20  13. Was Dec If Yes, sp. 1 Yes Decedent's Us Give kind of wife. DO NOT the Buil  Meiling Addra  311 Pi Disposition (No cremetory of the Con Cemetory of the	ip Code  901  edent of His edity Cubar  all Occupa  vork done d  use retired,  der  erce  ame of rother plect  etery  and Address  S J.	n, Mexicen, Puert Specify:  ation furing most of wor  18. Mother's Nan Bertha V and Number or Ru  Drive  e)	pecify Yes or No- o Rican, etc.)  king  me (First, Middle, Virginia mal Route Number  Silver S  Dete  .2/29/00	USA  14. Raca Black, Specify:  16b. Kind of Busi  Construct Maiden Sumeme, Scaggs W. City or Town, S Spring, M 20c. Location - C  Highland	nat Country?  - American Indian, White, etc.  White iness/Industry  ction  Stete, Zip Coda)  MD 20901  Sity or Town, State	res 2 💢										
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nediate Cause (Final	nejcause on each line.	death. Do no	500 Un	23a. Partl. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,  Approximate															
ease or condition ulting in death)  quentially list conditions, ny, leading to immediate use. Enter Underlying	b. PNEUM	to (or as a co	A						/3_										
cause. Enter Underlying Cause (Disaase or injury that initiated evants resulting in death) Last  Due to (or as a consequence of):  d.																			
II. Other eignificant conditions con	ntributing to death but no	ot resulting in t	the underlying	cause give	en in Part I.	23b. Did tobacco uss contribute to the causs of de													
HYDOTENS	sinal					1 Yee 2 No 3 Probably 4			I ₽ Unk										
11/10/200	STON								-										
EMPHYSE	= M A							available pr	ior to										
CHIPTISC	-10/17							of daath?	of caus										
						10)	res 201 No	1 ☐ Yes	2 No										
Was case referred to medical					ac Diago -4 C				77.13										
examiner?	Hospital:	AFI 65/0 :		Othe	or.			e (Canaik i)											
TE YES ZED NO	1 X Inpatient			DUA	4 Li Nursing r	-													
1 Natural 5 ☐ Pending	(Month, Day Yea	er) fnj	ury				, , , , , , , , , , , , , , , , , , , ,												
Z LI MODIONIII	29f Location (f	Straat and Number	e or Dural Doute	Number															
4 ☐ Homicida determined			, or notal nouta f	valiliooi,															
a. Certifier  (Check only  2 Medical Examin	sician: To the best of my	y knowledga, o	daath occurre	ed at the tim	ne, date and place	, and due to the	cause(s) and man	nnar as statad.	se(s)										
one)	and mannar stated.																		
. Signature and title of certifier				_															
100	wills			D42	403	1	DECEMA	SER 2/2	20										
Name and address of person who of	ompleted cause of death	(Item 23a) /T		(0)	700		,		V 0.										
A T AA A A A A A A A A A A A A A A A A	/ / /	T 0.	50,11810		111	1/0011	-10	10 201	30, Name end address of person who completed cause of death (Item 23a) (Type, Print)										
Ve 1 N 1 2 3 4	Wes case referred to medical axaminer?  II. Other eignificant conditions cond	uentially list conditions, y, leading to immediate se. Enter Underlying se (Disease or injury initiated evants	uentially list conditions, y, leading to immediate se. Enter Underlying se (Disease or injury initiated evants liting in death) Last  II. Other eignificant conditions contributing to death but not resulting in the liting in death but not resulting in the liting in death but not resulting in the liting in death but not resulting in the liting in death but not resulting in the liting in death but not resulting in the liting in death but not resulting in the liting in death but not resulting in the liting in death but not resulting in the liting in death but not resulting in death but	Due to (or as a consequence of sections), leading to immediate see. Enter Underlying see (Disease or injury initiated evants initiated evants at thing in death) Last Due to (or as a consequence of d.  II. Other eignificant conditions contributing to death but not resulting in the underlying the conditions contributing to death but not resulting in the underlying the conditions contributing to death but not resulting in the underlying the conditions contributing to death but not resulting in the underlying the conditions are consequence of the conditions contributing to death but not resulting in the underlying the conditions are consequence of the conditions are conditions.  II. Other eignificant conditions are consequence of the conditions are consequence of the conditions are consequence of the conditions are conditions.  II. Other eignificant conditions are consequence of the conditions are conditions.  II. Other eignificant conditions are conditions are conditions.  II. Oth	Due to (or as a consequenca of):    Due to (or as a consequenca of):	Due to (or as a consequence of):    Due to (or as a consequence of):	Due to (or as a consequence of):    Due to (or as a consequence of):	Due to (or as a consequenca of):    Due to (or as a consequenca of):	Due to (or as a consequence of):    Due to (or as a consequence of):										



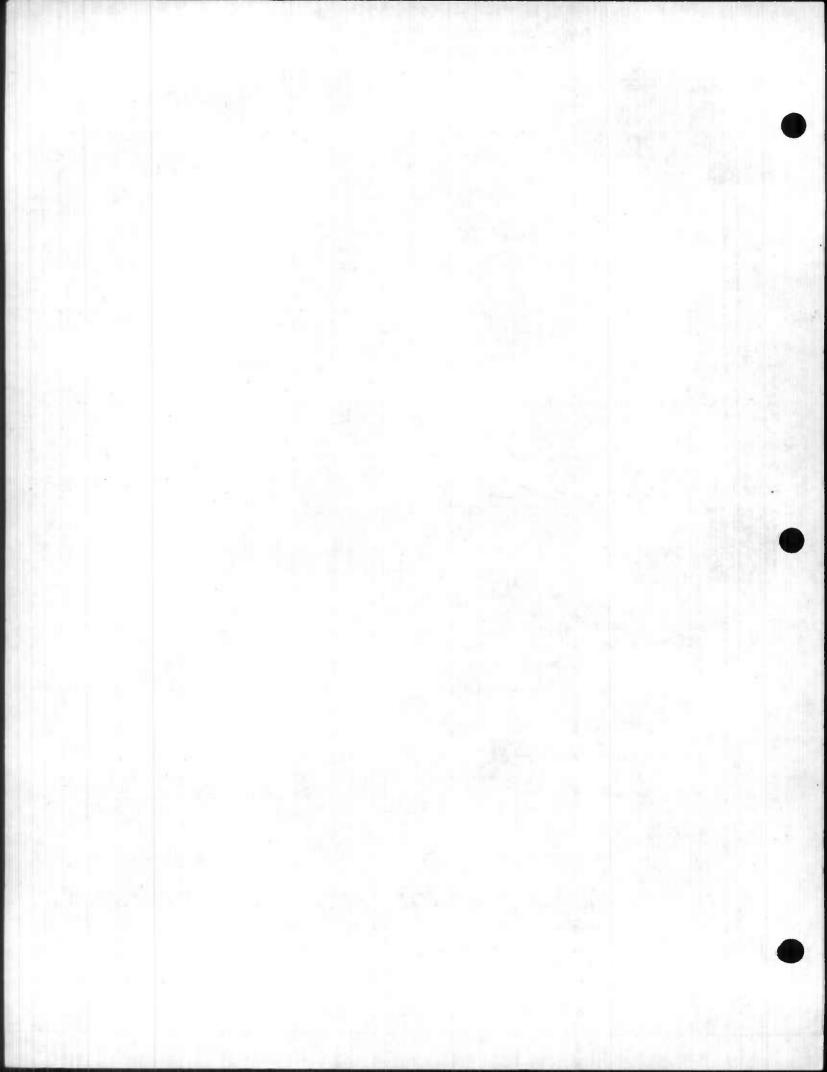
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State of Maryland / Department of Health and Mental Hygiene 0 4 2 7 7 2

	Certificate of Death Reg. No.											
	1. Decedent's Name (First, Middle, Last	Year	3. Tima of Deeth									
Physician /Medical	Hon	g-Ming Chen				Decemb	er 22, 2	2000	2:22 PM			
Examiner	4e Fecility Name (If not Institution, give			80		n, or Location of Deat						
	SHADY GROVE AL	OVENTIST HO	OSPITAL			KVILLE		TGOM				
Funeral Director	5. Social Security Number 6. Se 212-96-7151		rs. last birthdey). 85 Yrs.	If Undar 1 Months	Yaer If Under 24 Deys Hours	Min. (Month, Di	th ay, Year) 6, 1915	9. Birthple Count Tai	aca (State or Foreig try) Wan			
Pu »	Usuel Residence of Decedent  10a. Stete 10b. County	100	City, Town or Loc	cation				146	Dd. Inside City Limits			
ahon ahon baryle									1 ☐ Yes 2 ₺ No			
vith the Ma	Maryland Montgome  10e. Street and Number	ry	Derwo	10f. Zip C	ode.		10g. Citizen of V	What Count	In/2			
23a or	7400 Ottenbrook T	errace			20855		Taiw					
d within 72 hours after death with the Maryland digiene. Then 'nature!', or frems 23s or 28s-f show it the Medical Examine must be notified at Completed by Funeral Director	11. Maritet Status  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forcas?  1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Detas:		Ves Decede Yes, specif		n? (Specify Yes or No Puerto Rican, etc.)	Specify	e - Americe ck, Whita, e				
ed within 72 hours ygiene. or then 'neturel', t, the Medical Est Completed by	15. Decedent's Edu (Specify only highest grad		16a. Deced	ent's Usuel	Occupation	of working	16b. Kind of Bu	siness/ind	ustry			
C 1 2 3	Elementery/Secondary (0-12)	Cottege (1-4or 5+)			done during most of retired)	, working						
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buid be filed within Mental Hygiene.  streed other then atto event, the Marcon To Be Comp	17. Fathar's Nema (First, Middla, Last) Not Available					s Name (First, Middle		Θ)				
d 2 should be file th end Mental Hy 7 is marked othe traumatic event						Available						
2 sho	19a. Informant's Name/Reletionship (T)	vpe, Print)				or Rural Route Numb						
E = U P	Sheu-O Chen/Wife					race, Der						
2 2 2	20e. Method of Disposition  1	nemoval from Stata	0 3	Cremat	orium, Inc.	, 2000	20c. Location - Bethesd	a, Ma	aryland			
permit. Page Depertment of Important: If any Injury or once.	21. Signature of Funeral Service License	/	198 RG	Name and Obert O Wes	Address of Fecility A. Pumphi t Montgor	rey Funera mery Avenu Land 2085	1 Home/R	lockvi	ille, Inc			
	23e. Pert1. Enter the direasa, or comp shock, or heart failure. List only o	lications that causad tha d	aath. Do not ente	er the mode	of dying, such as co	erdiec or respiretory	arrest,		Approximate Interval Between			
Physician	Shoon, of heart failure. Elst only o	THE COURSE OF THE CAT IN IO.						1	Onset and Death			
/Medical	Immediate Cause (Final disease or condition	Pneumonia										
Examiner	resulting in death)											
ةِ تِ		Parkinson	o (or es a conseq LÍSM					1	Months			
cate be executed physician and s the burial-transit	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	bDue to	o (or es e conseq	uence of):		7.64			SP DV			
	Cause (Disease or injury that initiated events resulting in death) Lest	C. Dua Id	o (or as a consequ	uence of):								
deeth cert e attending ad for use												
the deeth y the atte sched for nysicia	Pert tt. Other significant conditions co	ntributing to death but not	nderlying ce	23b. Did	23b. Did tobacco uss contribute to the cause of death							
ras that the deeth certifiqued by the attending the deteched for use a by Physician/M					10	1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unkn						
aw requi		24a. Wes en eutopsy performed?							ere eutopsy findings ailable prior to mpletion of cause death?			
The law ate has be page 2 s						1 🗆	Yes 21 No	10	Yes 2 No			
certificate rector, page	25. Wes case referred to medical exeminer?				26. Place	of Deeth (Check only	one)					
	1 ☐ Yes 2 ☒ No	Hospitel: 1 Inpatient 2	ER/Outpetien	t 3[X DOA	Other: 4 Nurs	sing Home 5 Res	idence 6 DOth	er (Specif)	y)			
the real	27. Manner of Death  1 Neturel 5 Panding 2 Accident Invastigation	28a. Date of Injury (Month, Dey Year	28b. Time of Injury	28 M	c. Injury at Work? 1 Yes 2 N		how injury occur	red				
	3 Suicide 6 Could not be determined		28e. Place of Injury - At home, ferm, street, fectory, office 28f. Location						n (Street and Number or Rural Route Number, Town, State)			
he Hospital or in 24 hours aftu he Funeral Dir pletely filled in edical Ceri		sician: To the best of my liner: On the basis of exam and manner stated.										
ithin 2 the cappe	29b. Signatura and taleral certifier	and mailler stated.	/	290.	License number		29d. Date signe	d (Month.	Dey, Year)			
5 50	1///	7//										
'sa h	30. Name and address of person who co				7437				22, 2000			
	Angelo Falcone,	M.D. 9901 M	ledical (	Center	Drive, H	Rockville,	Marylan	d 208	350			
State Registrar	31. Data filed (Month, Day, Year) DEC 2 6 20	32. Registrer's Si	gnetura 6	do	alse							

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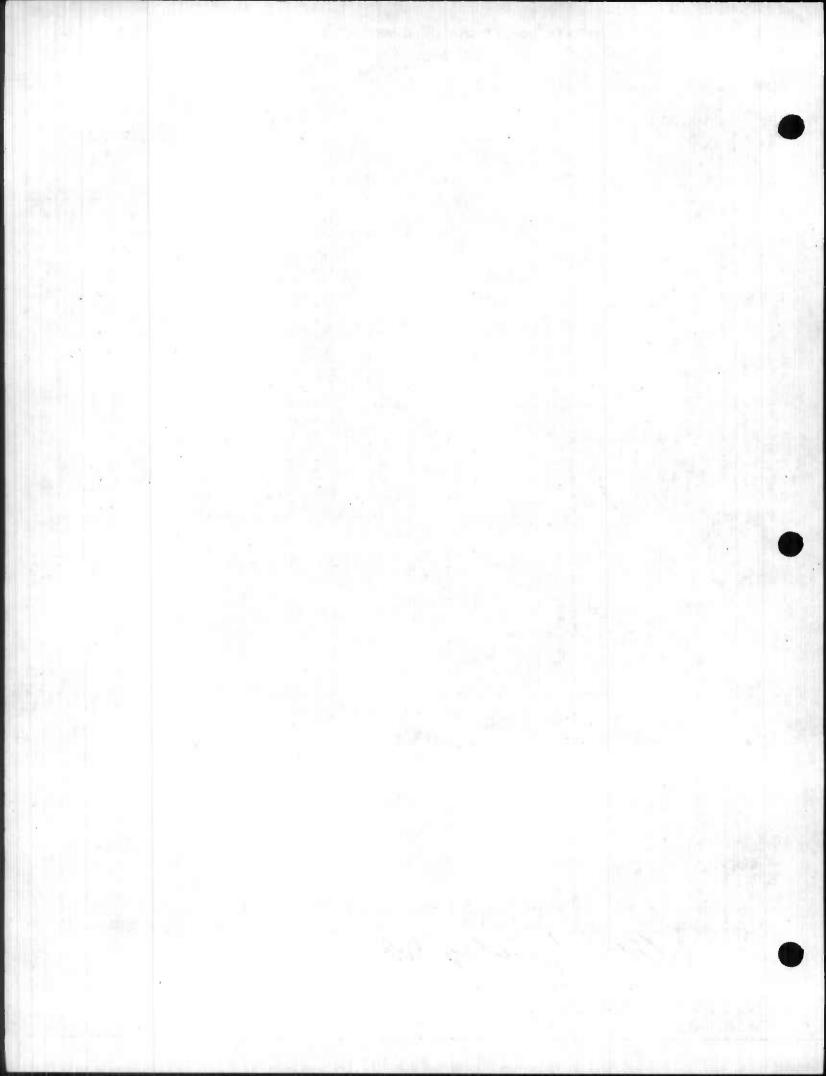
**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene

				Certifica	ate of	Death		Reg. No.	42/13			
	1. Decedent's Neme (First, Middle, La	est)		TO H			2. Date of Do	eeth Dev	3. Time of	Death		
Physician /Medical	Chit-Ming C	hang					Decemb	- 1		P.M.		
Examiner	4a Facility Name (If not institution, girls SHADY GROV	re street end number) 'E ADVENTIS	г но	SPITAI			, or Location of Deel		of Death ITGOMERY			
Funeral Director	219-88-2012	Sex 7. Age (In your 1		Yrs. If Und Month	er 1 Year s Deys		Min (Month, D	orth ay, Year) 9, 1917	9. Birthplece (Stete of Country) China	r Foreign		
D	Usual Residence of Decedent  10e. Stete 10b. County	10c.	City, Town	or Location					10d. Inside Cit	tv Limits		
with the Marylar s or 28e4 show be notified at Director	Maryland Montgom		rwoo						1 ☐ Yes			
or start or	10e. Street and Number	ery De	IWOO		Zip Çode			10g. Citizen of V	Vhet Country?			
23e o unit be rei Di	18525 Azalea Dr	ive			2085	5	ET 50	United	States			
ter des	11. Maritel Stetus  1 Never Married 2 Married  3 V Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates;	U,S.		cedent of l pecify Cub 2 No		? (Specify Yes or Noverto Rican, etc.)	Blac	e - American Indian, ck, White, etc.			
2 hou 2 hou ted ted	15. Decedent's E	ducation	16a.	Decedent's Us	sual Occu	petion		16b. Kind of Br	usiness/Industry			
Maryland 21215-0036 tid should be filed within 72 hours at the and Mental Hygient. 77 is merited other than "natural", or traumatic event, the Medical Exam To Be Completed by F	(Specify only highest gr Elementery/Secondery (0-12)	College (1-4or 5+)				petion during most of ad)	working					
Co Parent	42 Fathada Nama (First Middle Lace	4		Teach	ner	19 Mathada	Name (First Middle		Schools			
and diberi	17. Fether's Neme (First, Middle, Last Not Available						Neme (First, Middle vailable	, maiden sumen	9			
To To	NOT AVAILABLE  19e. Informent's Neme/Reletionship		10h	Mailing Adder	ass /Stran			Route Number, City or Town, Stete, Zip Code)				
Na salas	Kien C. Chang/So							Maryland 20855				
emit. Pages 1 an Appartment of Heal Apparant; if Item 2 ny fojury or other finds.	20e. Method of Disposition  1 Burial 2 © Cremation 3 [	200		Dec. 27,	20c. Location -	City or Town, Stete						
	4 Donetion 5 Other (Special		ntgome	ery Creme			2000		da, Marylan			
Departiment in poemit in p	21. Signeture of Funeral Service Lice	2	0198	Robert 300 We Rockyj	and Addr A. est M	Pumphre Pumphre ontgome Marvla	rv Avenue	Home/Ro -2805	ockville, I	inc.		
	23a. Pert1. Enter the disease, or con shock, or heart feilure. List only	plications that caused the de	eeth. Do r	not enter the m	ode of dy	ing, such as ca	rdiec or respiretory	arrest,	Approximete Intervel Bety	ween		
Physician									Onset end I	Death		
/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth)	Metastati	c Br	east Ca	ancer			100	3 month	ıs		
23	Due to (or as e consequence of):											
nine led		b										
68760, tificata be executed g physician and as the burial-transit	Sequentially list conditions, if any, leeding to immediate	Due to	o (or as e	consequence o	of):				1			
68760, fficata be extended by the purial as the burial ledical E	Cause (Disease or Injury that Initiated events resulting in death) Last  Due to (or as e consequence of):											
OX 68760, certificate be exected to the control of												
deeth cert a attendin set for use	Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part t.  23b. Did tobacco use contribute to the cause of death											
rds, P.O. Box (uires that the deeth certification is signed by the attending ild be detached for use and by Physician/M	Adult Respirator	10	1 Yes 2 No 3 Probably 4 Unk									
dS, signe dbe d	Atrial Fibrillation: Thrombooutopenia 24e. Was en autopsy									findings		
The law requires to the law requires to the seen signal, page 2 should be Completed by	Atrial Fibrillat	ion; Thrombo	ocyto	penia				lormed?	aveilable prior to completion of c	to		
Rec law hes mpl									of deeth?			
= F # 6 0		I			744			Yes 218 No	1 ☐ Yes 2 ☐	No		
Of Vital Re Physician: The la this certificate he ral director, page :: To Be Com	25. Wes cese referred to medicet examiner?  1 ☐ Yes 2 ☒ No	Hospitel: 1 tnpatient 2	□ ER/Ou	tosticat 2	DOA O	hor	Deeth (Check only ing Home 5 ☐ Res		per (Specify)			
Physic or this o eral dire	27. Menner of Death	28a. Dete of Injury (Month, Dey Year	28b. 1	Time of		ury et ork?	-	how injury occur				
often	1 Neturel 5 ☐ Pending investigetion			njury M		Yes 2□No						
DIVISION  Tor Attending after death. Director: After Jin by the fune ertification	3 Suicide 6 Could not leadermined	208. Flede of Injury - A	28e Plece of Injury - At home form street fectory office 28f. Location					(Street and Numi own, State)	ber or Rural Route Num	nber,		
DIVISION O To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7		hysician: To the best of my lominer: On the basis of exam								s)		
Med Med	29b. Signature and title of Christier	end menner steted.			29c. Licen	se number		29d. Dete signe	ed (Month, Dey, Year)			
F 3 F 8	Vadd/	. 1 . 1	11	11		540			r 21, 2000			
	30. Neme end address of person who					1 0	3 41 3	300	20077			
	Carl I. Schoenber	-		Freder:	ick F	Road, Ga	aithersbu	rg, MD	20877	-		
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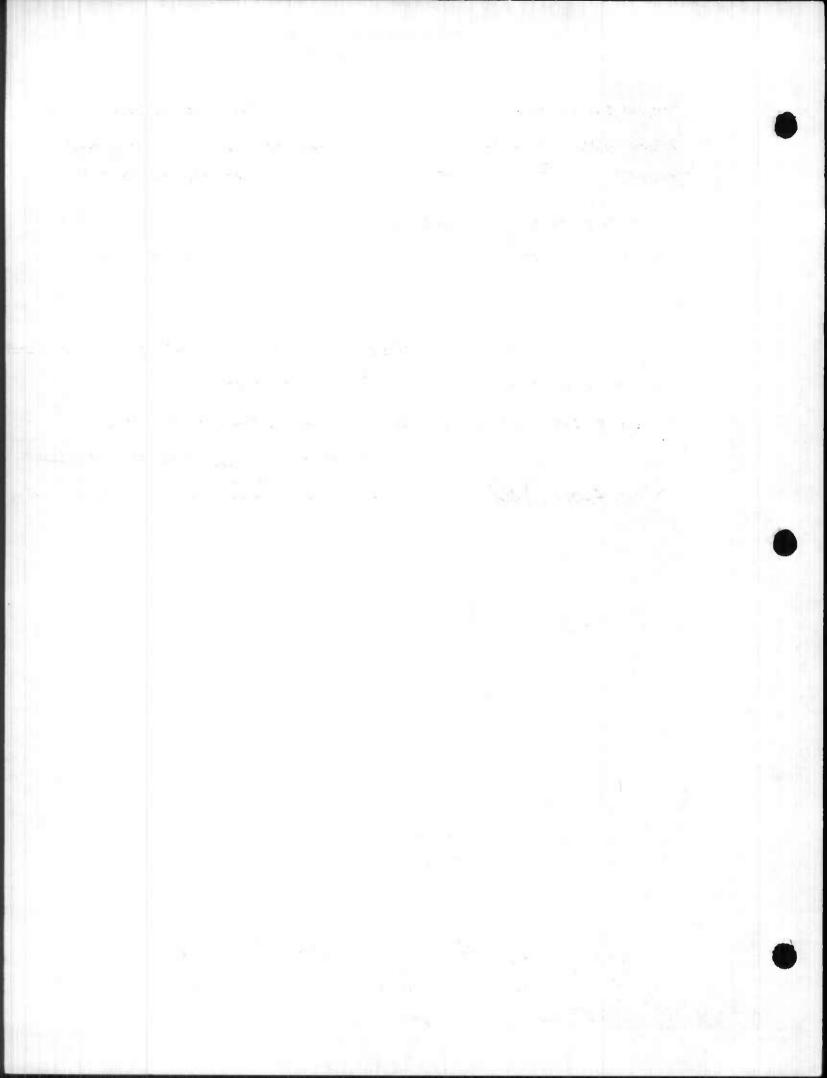


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Date of Death 3. Time f = th Month **Physician** Douglas Robson Chandler December 26, 2000 2:00=m /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gaithersburg

If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) Wilson Health Care Center Montgomery If Undar 1 Yaar Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foraign Country) **Funeral** Months 10 M 2□ F Yrs Director 218-26-8775 99 Mar. 30, 1901 New York Usual Residence of Decedant the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other treumstic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Directo Montgomery Gaithersburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Russell Avenue 20877 United States Funerai 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 □ Nevar Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 TNo Specify: White p 3 ∰Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highast grade completed) 16b. Kind of Businass/Industry Collega (1-4or 5+) 5+ Elementary/Secondary (0-12) Ordained Minister United Methodist Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Charles H. Chandler Katherine Orr 0 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) Suzannah E. Chandler (Daughter) 335 East 88th. St.-New York, N.Y. 10128 20b. Placa of Disposition (Nema of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burlat 2 ☑ Cremation 3 ☐ Removal from State 12/26/00 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Lice 22. Name and Addrass of Facility DeVol Funeral Home 10 East Deer Park Drive - Gaithersburg, MD. 2087 art 1. Egter the diseaser or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Cause (Final diseasa or condition resulting In death) 1 week preumoni Examiner Due to (or as a consequence of): Examiner dem eimy physician and the burial-fransit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting In death) Last Due to (or as a consequence of) Box 68760 Physician/Medicai Dua to (or as a consequence of): usa signed by the at id be datached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 22 No 3 Probably 4 Unknown à 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed peen paga 2 s has 1 Tes 2 XN0 1 ☐ Yes 2 ☐ No cartificata To the Hospital or Attending Physicien: within 24 hours after death.

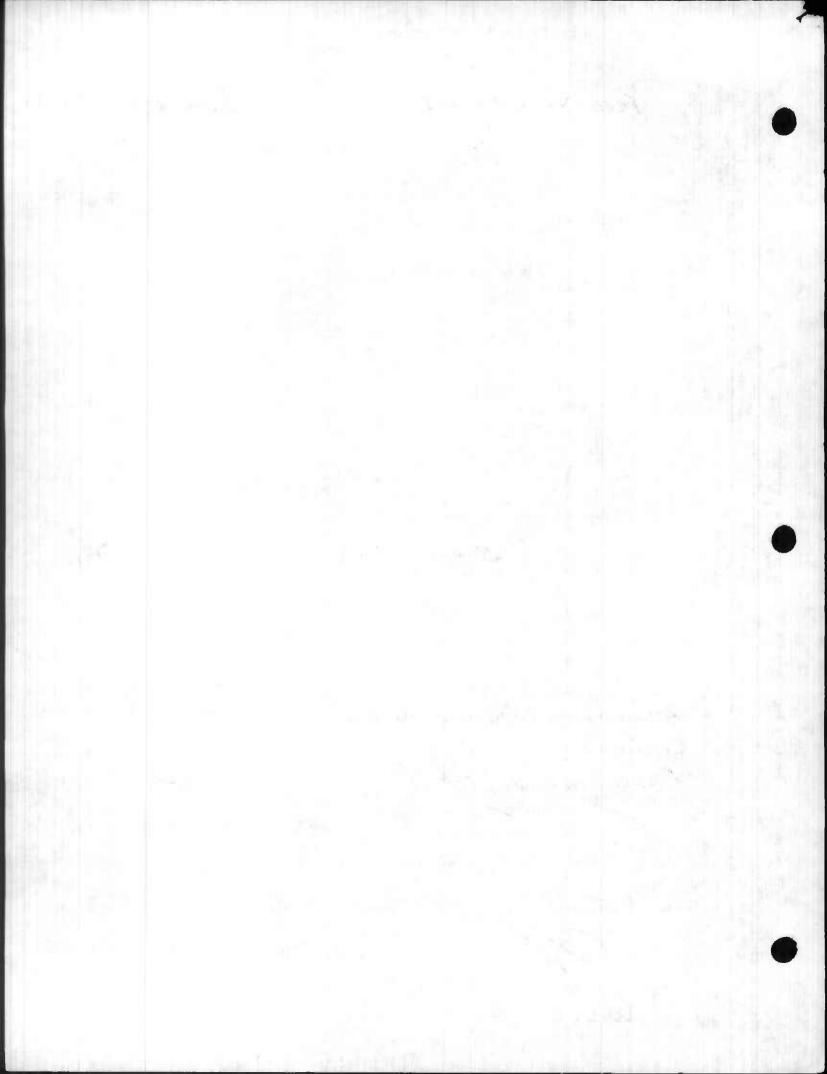
To the Funeral Director: After this cartification completely filled in by the funeral director, 25. Was case referred to medical axeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending investigation 1 Neturel 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(a) end menner es steted.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) NH 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) R. John MELNICH RUDELL AVE GAITHENSOURG mel 911 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State Prava DEC 27 Registrar



State of Maryland / Department of Health and Mental Hygiene 1 2775

	Certificate of Death Reg. No.										
Physician , /Medical	1/00/00/12								Yaar 2000	3. Tima of Deat Z:00 P.	
Examiner	4a Facility Name (If not institution, give Howard County Ger	neral Hospit		. Williams		C	olum	r Location of Death  4c. County of Death  1mbia Howard			
Funeral Director	258-24-5858	7. Age (In y	rs. last birthday 4 Yrs.	Months	Days	If Under: Hours	Min.	8. Dale of Birth (Month, Day May 17,	1926	9. Birthp Cour Geo:	laca (Stata or Ford try) rgia
28a-f ahow nouthed at rector	Usual Residence of Decedant  10a. State 10b. County  Maryland Howard	10c.	City, Town or L						4	1	0d. Inside City Lin 1 ☐ Yes 2🛣
0 % 0	10e. Street and Number 7070 Cradlerock Wa	av. #215		10f. Zip	Coda 210	45			10g. Citizen of '	What Cour	itry?
F. or he	11. Marital Status  1 Naver Married 2 Married  3 Widowed 4 Divorced	12. Was Decedant Evar in Armed Forcas? 1 ☑ Yes 2 ☐ No If Yas, Giva Yaar or Datas: 1942		Was Deceded If Yas, special	ent of H ify Cuba	ispanic Origin, Maxican	gin? (Spe , Puarto	ecify Yas or No- Rican, atc.)	14. Rac	ca - Amaric ck, Whita,	
ygiene.  The Medical  Completed	15. Decedent's Edu (Specify only highest grad	ucation la completed)	16a. Dece	edent's Usua a kind of work DO NOT us	Occup	ation during most	of worki	in <i>g</i>	16b. Kind of B	usiness/Inc	dustry
then.	Elementary/Secondary (0-12)	Collega (1-4or 5+)	IIIa.	Sales					Kraf	t Foo	าสร
T 8 0	17. Father's Nama (First, Middle, Last)  James Chambers			0.000		18. Motha		(First, Middle,	Maiden Sumar		
marked marked	19a. Informant's Name/Ralationship (T	ivne Print)	19h Mei	ling Addrass	/Straat			Laura D		Stata. Zio	Coda)
27 is m	Ms. Mary Wilson /							aurel,			707
Department of Health important: If item 27 is any injury or other tra	20a. Mathod of Disposition   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Classifier   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition (Nama of cematary, crametory or other place)   20b. Place of Disposition										
ysician Medical kaminer	23d. Part1. Entar tha disaasa, of comp shock, or haart failura. List only of Immediata Cause (Final disaasa or condition rasulting in deeth)	s. SEP	aath. Do not ar	SHoc		ng, such as	cardiac (	or raspiratory ar	rast,	2	Approximata Interval Between Onsat and Deat
e attending physician and ider use as the burial-transit is ician/Medical Examiner	Sequentially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last	c	o (or as a conse								
the attend hed for us /siclan/	Part II. Other significant conditions co	ntributing to death but not	resulting in the	undarlying ca	ausa giv	an in Part I		23b. Did tobacco use contribute to the cause of de			
igned by the be detached by Physic	Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa givan in Part I.  An theroschecatic Combio Ussuelas dissesse							U	2 No 3 Probably 4		
should should	CHONICO O Structure Perlineury Disease 24a. Was an autopsy performed?							an autopsy med?	av	ara autopsy findir ailabla prior to impletion of cause deeth?	
certificate has rector, pege 2	Cinseles wal	leiker . To	DE 17					101	as ello	11	Yes 20Ho
s certific director,	25. Was casa rafarred to medical examinar?	Hospital:	5-20		Oth	ar.		h (Check only o			
	1	28a. Data of Injury (Month, Day Year	2 ER/Outpation 28b. Tima Injury		8c. Injui Woi	4 LINU		oma 5 ☐ Resid 28d. Dascribe I			9)
	3 ☐ Suicide 6 ☐ Could not be datarmined	28e. Plece of Injury - A building, atc. (Spe	At homa, farm, s	traat, factory	, office			28f. Location (S City or Tox		ber or Run	al Routa Number,
24 hour Funer Stely fill	29a. Certifiar (Check only one) 1 Oct Tifying Phy 2 Medical Exam	raician: To the best of my liner: On the basis of exam and manner stated.	knowledga, dae nination and/or l	th occurred a invastigation,	at tha tir	ma, data an opinion, dea	d placa, th occur	and dua to the red at tha tima,	ceuse(s) end m deta and plece	annar as s , and dua t	tated. o tha causa(s)
within To the comple	29b. Signatura and titla of collection	//		29c	. Licans	a number			29d. Date sign	ad (Month,	Day, Year)
5	30. Nema and address of person who c	completed causa of deeth (	Item 23a) (Type	Print)	)20	285	6		Lecen	Non 2	3,200
AULU	Leug In hay	a 8,000, 110	55 het	Ke for	21/0	SH	4	Leu Gis	obst 2	250	7
State Registrar	31. Data filed (Month, Day, Year) DEC 2 7 20	32. Degistrar's Si	ignatura &	Lon	do						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** December 25, 2000 8:27 AM Dorothy Williams Carter /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda 9512 Edgeley Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1□M 20 F Yrs. Director 350-16-0817 76 October 16, 1924 Missouri Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits the Marylar r than "natural", or liente 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9512 Edgeley Road 20814 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 ☐ Never Married 2 Merried 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 24 Bro. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be the Department of Health and Mental Hy Important: If them 27 is marked oth any Injury or other traumatic even 8 Russell John Williams Dorothy Atkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert E. Carter/Husband 9512 Edgeley Road, Bethesda, Maryland 20814 Baltimore, 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition December 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 29, 2000 Silver Spring, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 21. Signature of Funeral Service Licensee M00198 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Plasma Cell Cancer 18 Months Examiner Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): 88 attending 950 ò signed by the a 23b. Did tobacco use contributa to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yea 2 No 3 Probably 4 ♥ Unknown Atherosclerotic Vascular Disease, Multiple by 24b. Were eutopsy findings evallable prior to completion of ceuse of death? been si 24a. Wes en autopsy performed? Completed Cardiovascular Accidents has 1 page ours after death.

eral Director: After this certificate I filled in by the funeral director, pag 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? Certification: Hospital or Attending 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral E 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

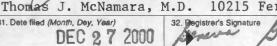
| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. edicai npletely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

20

State Registrar 31. Dete filed (Month, Dey, Year) DEC 27 ZUUU

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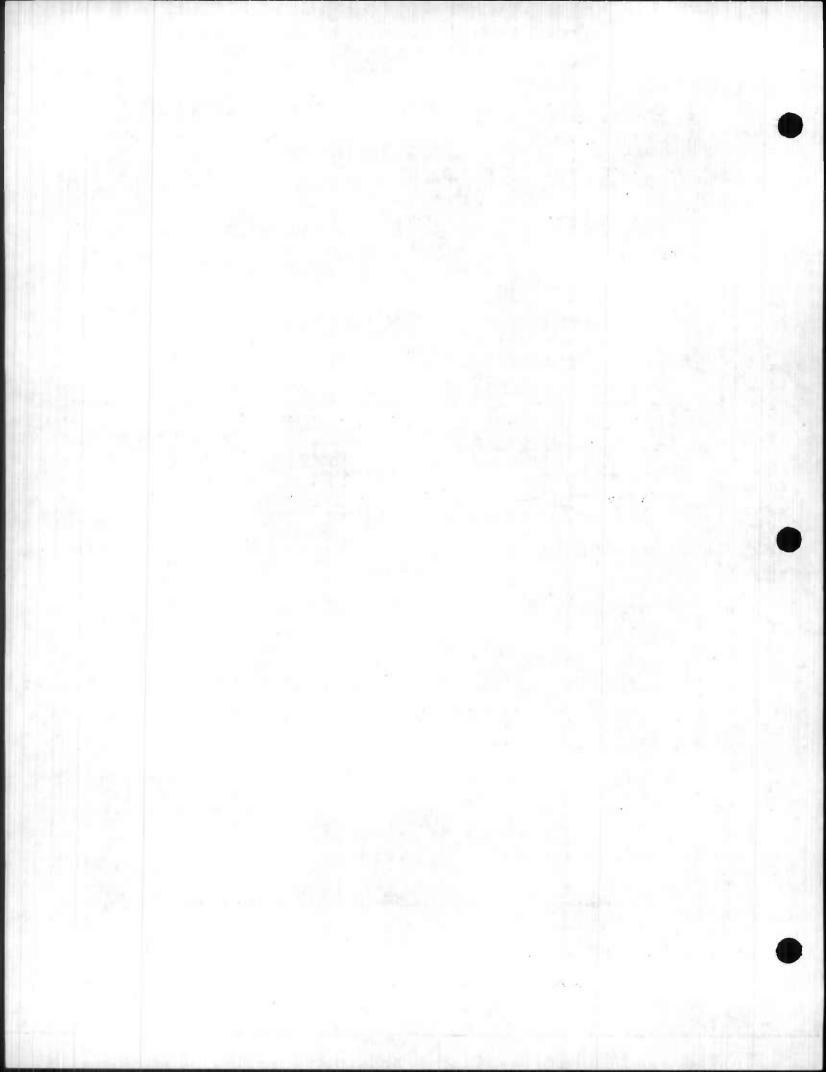
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



10215 Fernwood Road #100, Bethesda, Maryland 20817 rocks

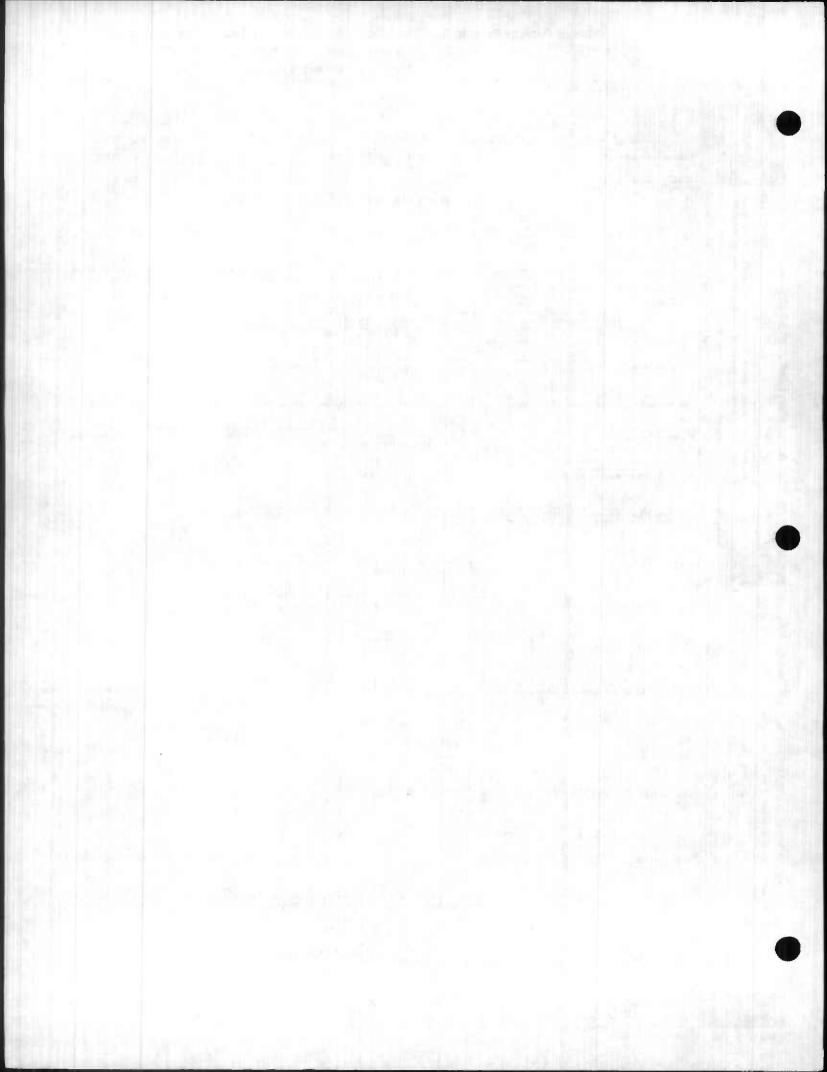
D32610

December 26, 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

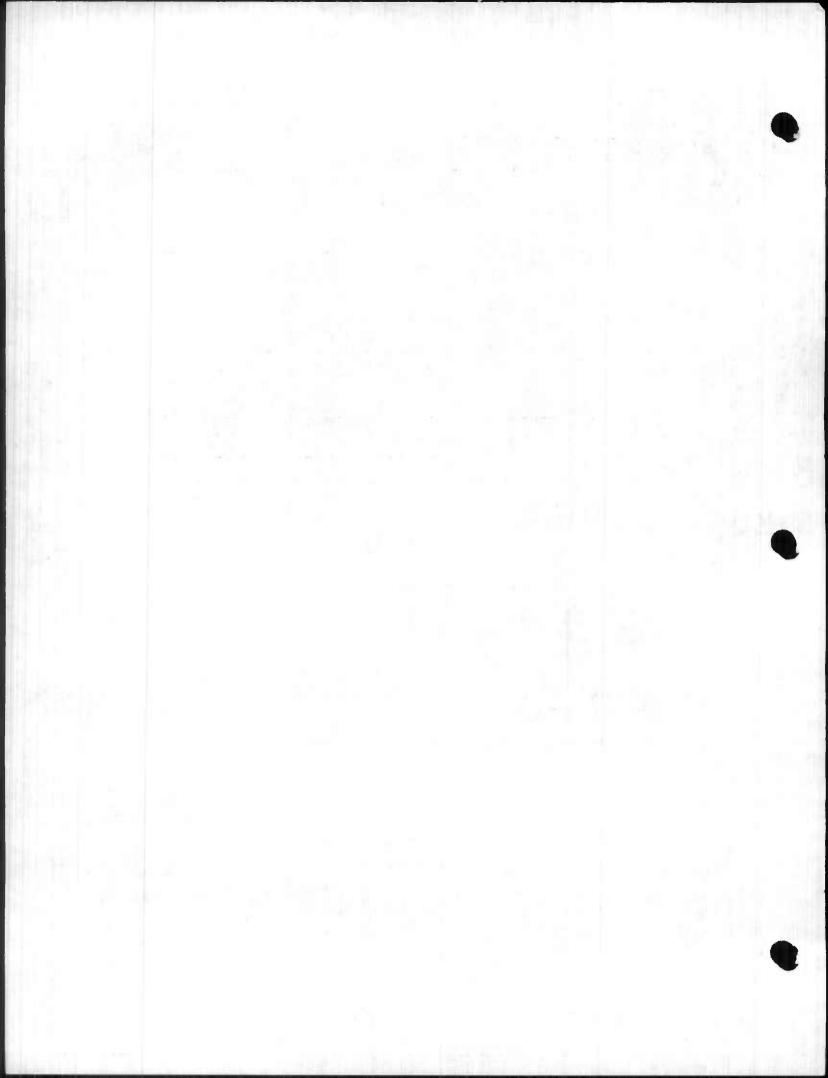
					Cei	rtifica	e of l	Death			Reg. No.				
		1. Decedent's Neme (First, Middle	e, Last)	12-1			78.T			2. Dete of De			3. Time of Death		
dp.	Physician	Eleanor F. Car	r							Month	er 26.	Year 2000	8:05 am		
	/Medical Examiner	4a Fecility Neme (If not institution		ber)			4	b. City, To	wn, or Lo	cation of Deet	h 4c. Count	y of Death	10.03 all		
4	Examine	Shady Gro	ve Adven	tist H	Hospit	tal		Roc	kvi	lle	Mo	ntgo	merv		
-	E-mark	5. Social Security Number		. Age (In yrs.			r 1 Year	If Under							
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Maryland 21215-0020	2 show and M is man	19a. informent's Name/Reletions		1961	19b. Meilir	ng Addras					Jumber, City or Town, State, Zip Code)				
ž	Tot Heat If Item 2 or other	Libbie C. Harr/ Daughter 18264 Metz Drive, Germantown, M									MD 20				
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Division		3 Suicide 6 Could	nined 256. Place	of fnjury - At ho	ome, farm, ste	reet, facto	ry, office					nber or Rur	rel Route Number,		
á	Direct din	4 Homicide	buildin	g, etc. (Specify	y)					City or 10	iwn, Stete)				
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	15	Vuen					536	01.			Decemb	er 26	, 2000		
		30. Nama and addrass of person	who complated ceusa	of daeth (Itan	n 23a) (Type,	Print)									
		I Jaz Mohsin,		9 Rock	ville 1	Pike	#100	, Roc	kvil	le, MD	20852				
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State of Maryland / Department of Health and Mental Hygiene 0 4 2 7 7 8

		Certificate of Death Reg. No.										
	1. Decedent'a Nama (First, Middla, I	ast)						2. Date of Dea		Voor	3. Tima of Deeth	
Physician /Medical	MARY -	CA	RL					DECEMBE	R 22,20	000	12:25 PM	
Examiner	4a Facility Name (If not institution, S MONTGOMERY GENE					01	NEY	ocation of Death	MOI	of Death	ERY	
Funeral Director	502 64 8521	Sex 1 M 2 F 7.	Age (In yrs. last birth	Months	Deys Deys	If Undar Hours	24 Hrs. Min.	8. Data of Birt (Month, De) SEPT. 2	7, Yeer) 9,1953	Cour	plece (Stete or Foreign htry) H DAKOTA	
-f show fied at	Usual Residence of Decedent  10a. State 10b. County  MD. FREDER	RICK	10c. City, Town	or Location EDERICK						1	0d. Inside City Limits	
a or 2ta-f a Lbe notified Director	10e. Street and Number 1310 HAMPSHIRE	DDIVE		10f. Zip (	Coda 207	702			10g. Citizen of 1			
Examiner must. By Funeral	11. Marital Status  1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force	s? XNo	13. Was Decede If Yas, speci	ent of I fy Cub	Hispanic Or ean, Mexica		ecity Yes or No Rican, etc.)		ca - Americ ck, Whita,	an Indian, atc.	
ygiene. ser than 'natura' it, the Medical if	15. Decedent's (Specify only highest s Elementery/Secondary (0-12)			Decedent's Usual Giva kind of work ife. DO NOT use	done	during mos	st of work	ing	16b. Kind of B	usiness/Ind	dustry	
ted other that ic event, the lo	12 17. Fether's Name (First, Middle, La MA YO – CAF	2		SPIRATOR	RY			me (First, Middle, Maiden Sumeme)			CAL	
27 is mark r traumation To	19a. Informent's Neme/Relationship	19a. Informent's Neme/Relationship (Type, Print)  19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code)										
0.00	20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3  4 ☐ Donetion 5 ☐ Other (Spe		cemetery	Disposition (Nem cremetory or off OLITAN (	her pla		12	Dete 2/24/00	20c. Location			
	21. Signature of Funeral Service Lic		her	22. Marra and	LAddr	ess of Becili	BER	FUNERAL	HOME			
	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus	ed the daath. Do no							). 20	Approximate Interval Betwaen	
ysician Medical caminer	Immediate Ceuse (Finel disease or condition resulting in death)	e. GRAM	NEGATIVE  Due to (or as a co	SEPSIS						1	24 HRS.	
attending physician and I for use as the burial-transit Clan/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as e consequence of):  C.  Due to (or as e consequence of):											
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page Som								域	res 2□No	भ	√Yes 2□ No	
Be Be	25. Was case referred to medical examiner?	Hospitel: 🏑.			-		e of Dea	th (Check only o	one)			
After this of funeral dire	1 Yes 2 No  27. Manner of Death  1X. Neturel 5 Pending investiget	28a. Dete of in		ne of ury M	Bc. Inju Wo			ome 5 Resident			fy)	
as after death.  as Director: After to led in by the funeral Certification:	2 Accident Investiget 3 Suicide 6 Could not 4 Homicide determine							28f. Location ( City or To	Street end Num vn, Stete)	ber or Run	el Route Number,	
Funer Funer Raly fill		Physician: To the be aminer: On the basis and manner	of examinetion end/									
To the comple	29b. Signature and title of certiful and tit	o completed causa o	Jojus f death (Item 23a) (T	(vpe, Print)	)241				29d. Date signo		Day, Year) 3,2000	
	ARTHUR F. WOODWA	ARD, JR., 3	416 OLAND	WOOD COL	JRT.	, OLNE	ΞΥ, Ν	1D. 2083	32			
State Registrar		2000	Sure Signatura	. doo	el.							



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Yaar Month **Physician** Campbell December 24, 2000 8:15 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George Clinton If Under 1 Yeer | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) March 15, 1925 7. Age (in yrs. last birthday) 9. Birthplece (Stata or Foraign 5. Social Security Number **Funeral** Min. Days Hours Months 1□M 20 F Burke Co., GA 75 253-52-5136 Director Usual Rasidence of Decedant 10c. City, Town or Location 10a. Stata 10b. County 10d. fnslda City Limits MD Prince George Ft. Washington 1 ☐ Yes 2 No Directo 10a. Street and Number 10f. Zio Coda 10g. Citizen of What Country? 4406 Cimarron Lane 20744 IISA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva X Yaar or Datas: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, etc.) Black, Whita, atc. 1 Navar Marriad 2 Married 5 1 Yas 2 No Specify: Specify: þ 3 Widowed 4 Divorced Black. 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) (Giva kind of work dona during most of working lifa. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Mentel I Della Walker Jack Campbell 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) pue 19a. tnformant's Name/Ratationship (Type, Print) Rosa King - Daughter 4406 Cimarron Lane Ft. Washington, MD 20744 Health am 27 i Baltimore, I 20c. Location - City or Town, Steta 20b. Place of Disposition (Nama of cematery, crematory or other place) Data 20a. Mathod of Disposition Pages ment of I 1 X Burial 2 ☐ Crametion 3 ☐ Ramovel from Stata Richmond Hill Cemetery 12/30/00 Hephzibagh, GA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Junaral Sarvice License 22 Name and Address of Facility neral Service, Inc. Alexandria, VA 22310 5517 Vine Street 23a Party Enlar the disaasa, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, and the mode of dying, such as cerdiac or respiratory arrest, and the mode of dying, such as cerdiac or respiratory arrest, and the mode of dying, such as cerdiac or respiratory arrest, and the mode of dying, such as cerdiac or respiratory arrest, and the mode of dying, such as cerdiac or respiratory arrest, and the mode of dying, such as cerdiac or respiratory arrest, and the mode of dying are the mode of dying. **Physician** tmmediata Cause (Final diseasa or condition resulting In deeth) /Medical Congestion heart failure due to Myocardial infantis **Examiner** infarction. Anterro wall Examine Sequentially list conditions, if eny, laading to immadiate causa. Enter Undarlying Cause (Disease or Injury that initiated avants resulting in death) Lest Dua to (or es e consequance of) Physician/Medical Due to (or as e consequance of): 88 USB Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Uliknown Dementia of Alzhain Cyce P 24b. Ware eutopsy findings available prior to 24a. Wes an autopsy performed? Completed amphell, Fannie completion of cause of death? page 2 s 1 Yas 2 No 1 Yas 2 No 25. Was cesa referred to medicel axeminar? Be 26. Placa of Death (Check only ona) Hospital: To Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 1 ☑ Natural 28b. Tima of Injury 28d. Describe how injury occurred 28c. fnjury at Work? 5 Pending investigation 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicida 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred et tha time, date end place, and dua to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred et tha time, date end place, end dua to the cause(s) end mennar stated. 29a, Cartifier To the Hosp within 24 hor To the Fune completely fi 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number 12.24.00 Roiter Falen M.D. 1243446 30. Nama and address of person who complated ceusa of death (Itam 23a) (Type, Print)

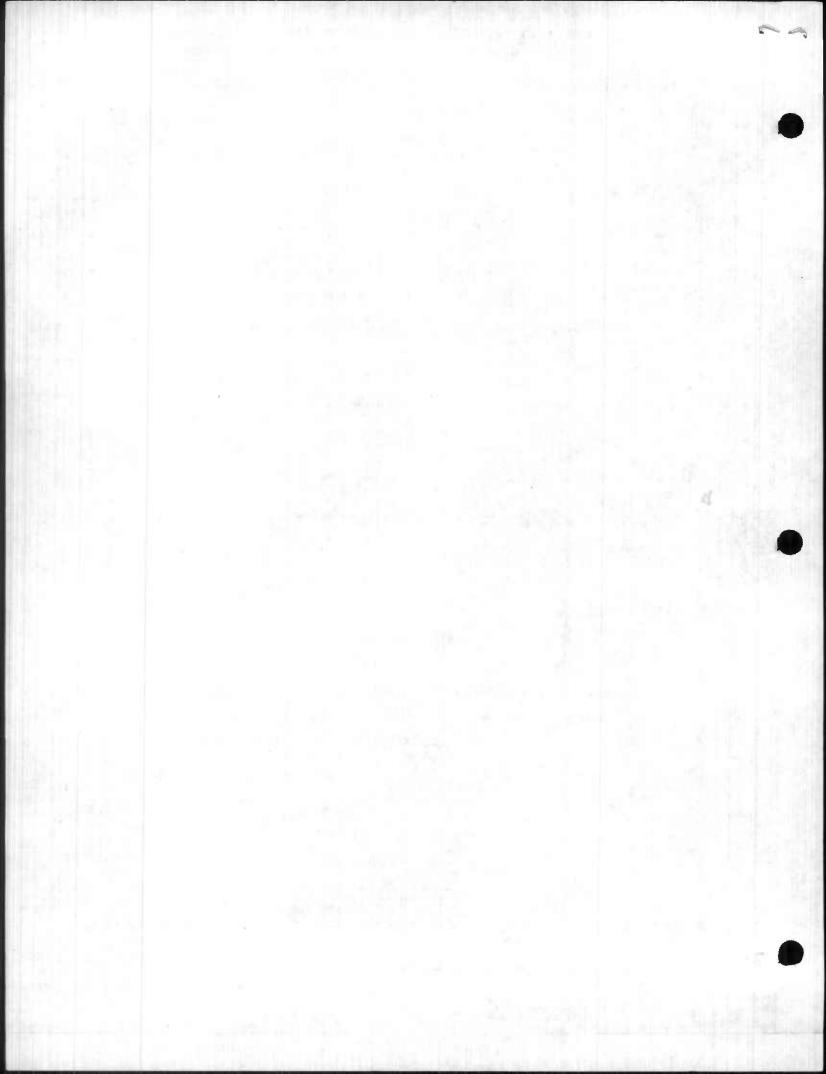
State Registra

**DHMH 16 Rev 6/95** 

31. Data filed (Month, Day, Year)
DEC 2 8 2000

32. Begistrar's Signatura

ROINTAN FARAHIFAR. MD. 9801 Georgia Ave Suit 3-35 SILVER SPRING-MD



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 42780 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Calloway Jacob Sawyer 23, 2000 December 1325 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Villa St. Michael Nursing Home Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 M M 2 □ F 75 Yrs. 226-24-8442 Jan. 13, 1925 Virginia Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Baltimore Baltimore 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 4007 West Strathmore Avenue 21215 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 23 No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: African 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Restaurant 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unavailable Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Cade/Daughter 3828 2nd Street, S.E. Washington, D.C. 20032 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory, Inc 12/28/00 Beltsville, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. lliberri 7400 Georgia Avenue, N.W. Wash., D.C. 20012 23s. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcenoma Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes an autopsy performed? Dulpionary auson 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending

Permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Haalth and Mental Hygiena.
Important: If item 27 is merked other than any highy or other trainment. **Physician** /Medical **Examiner** 

Examiner

Physician/Medical

by

Completed

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Certification:

edicai

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

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**Physician** 

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**Funeral** 

Director

7 is merked other than "natural", or items 23s or traumatic event, the Medical Examinar must be

with the Maryland r 28a-f show

> physician and the buriel-transit ettending pl ed by the e cartificata hes page

the deeth certificate be executed this funerel death.

Division of Vital Records, P.O. Box 68760,

or Attending 2 after 24 hours after Funeral Dire letaly filled in b

To the Hosp within 24 hou To the Fune completaly fi 2

> State Registrar

Welau MD

6 ☐ Could not be

1 Dertifying Phyeictan: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and manner as stated.

2 Medicat Exeminer: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) and menner stated. 29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE MD 2121 UBEROIMD 4419

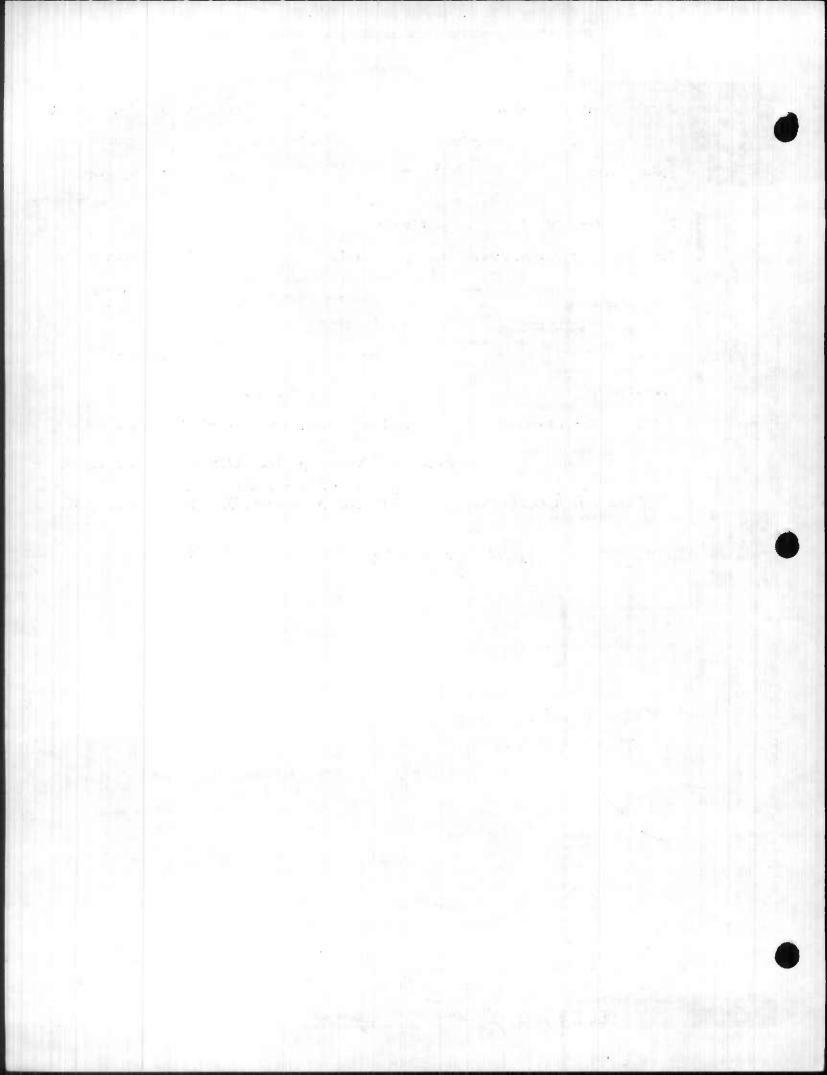
31. Date tiled (Month, Day, Year)

29b. Signature and title of certifier

DEC 29 2000

32. Registrar's Signeture

28e. Plece of Injury - At home, farm, street, tactory, office building, etc. (Specify)

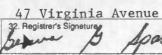


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Funer Directe	al	213 10 3203		(In yrs. last bir				Allega 1922	ny Birthplaca (State or Foreign Country)			
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23e or	ā	14 Massachuset	ts Avenue		10f. Zip Code	21502	10g.	USA	it Country?			
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of a short of the control of the con	To	19e. Informent's Neme/Relationship (	Type, Print)	196	Meiling Address (Street Elde	et and Number of Ri r Street	ural Route Number, C	ity or Town, Stand Mi	nte, Zip Code) D 21502			
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	mo.		1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No							
elctan: The certificate irector, pag	Be	25. Wes case referred to medicel examiner?					ath (Check only one)					
Physic rthis co	10	1 ☐ Yes 2 ☑ No	Hospitet: Impatier		Itpetient 3LI DOA		lome 5 ☐ Residence					
tending leath. lor: Afte	Certification:	27. Menner of Death  1. Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not by		Year)	M 1	njury at Vork? □ Yes 2 □ No	28d. Describe how					
Ital or Attending after death		4 Homicide determined	28e. Plece of Inju building, etc	ry - At home, fe , (Specify)	rm, street, fectory, offic	ж	City or Town, S	Refe)	or Rural Route Number,			
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	ledical	(Check only 2 Medical Exar		examinetion an	e, deeth occurred et the d/or investigetion, in m	y opinion, deeth occi	urred at the time, date	end plece, end	d due to the ceuse(s)			
To the Within 2 To the comple	2	29b. Signeture end titte of certifier	0		29c. Lice	ense number		Month, Day, Year)				
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State Registrar

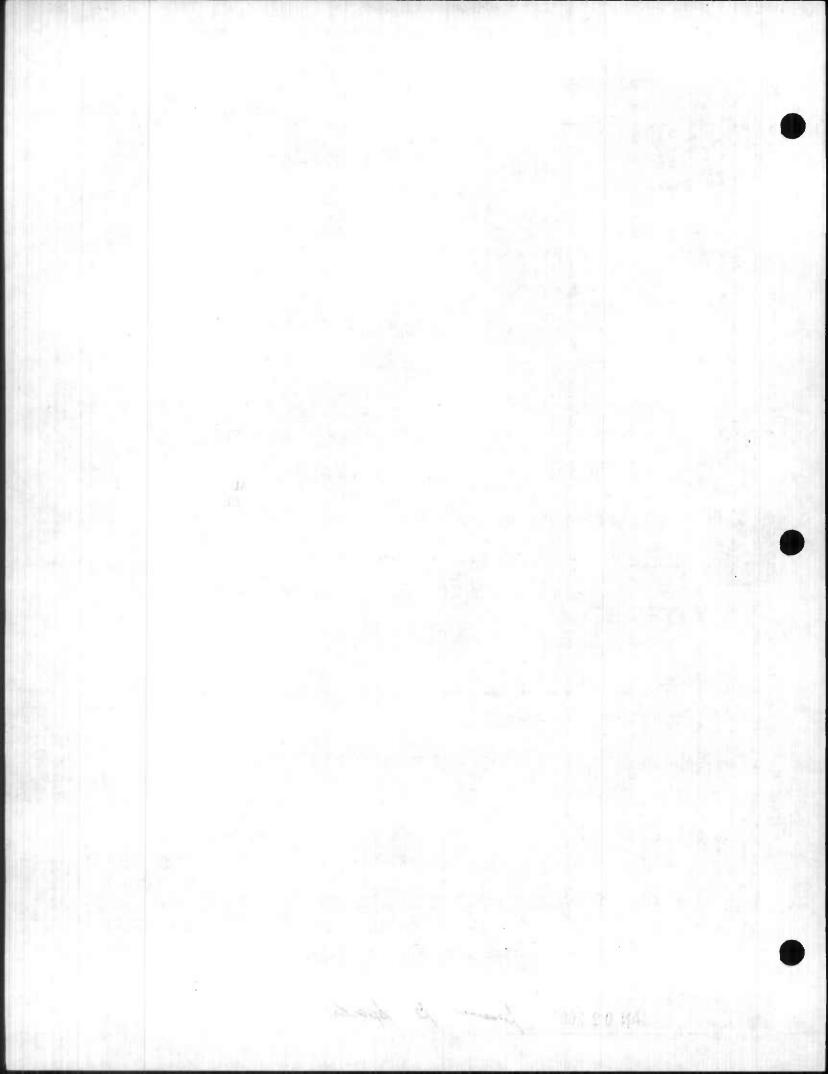
Dr. William D. Lamm
31. Date filed (Month, Day, Year) JAN 02 2001



30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)

Cumberland, MD

21502



Please Type or Print in Biack Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. t. Decedant's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day Month Year DEC. 24, 2000 ALICE R. DUKES 11:00 AM 4a Facility Name (If not institution, give street and numbar) 4b. City. Town, or Location of Death 4c. County of Death Mariner Health at Circle Manor KENSINGTON MONTGOMERY 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 24 Hrs. Birthplece (State or Foreign Country) Months Deys Hours 1 M 2 XF 217-32-1816 87 Yrs. 18,1913 Apr. Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. Stata 10b. County tOd. inside City Limits 1 ¥Yas 2 □ No Washington, DC 10g. Citizen of What Country? 10e. Sfreet and Number 10f. Zip Code U.S.A. 1411 Crittenden Street, NW 20011 14. Race - Amarican Indian, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2X No If Yas, Give Yeer or Detes: 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: 3 Widowed 4X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Home Domestic yrs 18. Mother's Name (First, Middle, Maiden Sumema) 17. Fathar's Nama (First, Middla, Last) Lula Hawkins Ernest Stewart 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20011 19a. informent's Neme/Relationship (Type, Print) 1411 Crittenden St., NW, Washington, DC Marie A. Swails (Daughter) 20c. Location - City or Town, Stete 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date Burial 2 Cremetion 3 Removal from State Rock Creek Cemetery 12/30/00 Washington, DC 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. valu 20 246 N. Wash. St., Rockville, MD 20850 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart faulure. List only one cause on each line. Approximate Interval Between Onsef and Death Immediete Cause (Finel disaase or condition resulting in deeth) Burels On Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequance of): Due to (or as e consequence of):

**Physician** /Medical Examiner

Examine

Physician/Medical

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Completed

Be

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Certification:

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

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A. Pages 1 and 2 should be fileOepathant: If the 37 is mary
way injury or other tree.

Baltimore, Maryland 21215-0036

must be notified

Director

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physician and the burial-transit 98 980 ö ed by the a signed by t should I 99 page 2 certificate After this Director: After this d in by the funeral death.

that the deeth certificate be executed

The lew requires

Physician:

or Attending

after

To the Hospital o within 24 hours af To the Funeral Di

completely

Division of Vitai Records, P.O. Box 68760,

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Was en eutopsy performed?

26. Place of Deeth (Check only one)

24b. Were eutopsy findings aveilable prior to completion of cause of death?

2 0 No 1 Yes

t ☐ Yes 20 No

25. Was case refarred to medical examiner? 1 Yes (No 27. Manner of Deeth

Hospitel: 28a. Date of Injury (Month, Dey Year) 5 Pending invastigation

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

Other: Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

t 💢 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signeture and title of certifier NO

6 Could not be determined

Diphre Henkin, mo

29d. Date signed (Month, Dey, Year)

31. Dete filed (Month, Dey, Year)

Road eld earfer.

State Registrar

DEC 28 2000

32. Registrar's Signatura

executed requires that the death certificate be P.O. Records, The law of Vitai Physician: Hospital or Attending P
 24 hours after death.
 Funeral Director: After t Division yd ni bellii To the Hospital within 24 hours a To the Funeral Completely filled

Maryland

Baltimore.

edicai 0

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

MD

8630 Fenton Street, Suite 230, Silver Spring, MD

29c. License number

D 00143

29d. Date signed (Month, Day, Year)

December 27, 2000

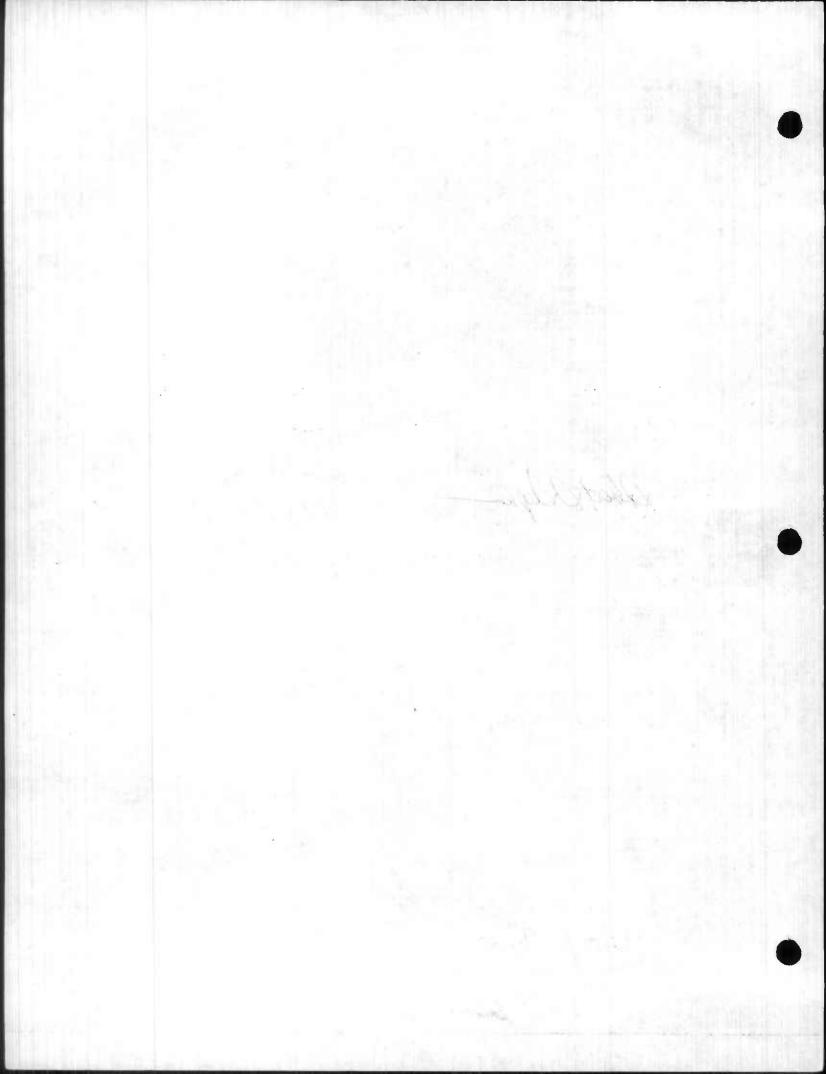
State Registrar

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29b. Signature and title of certifier

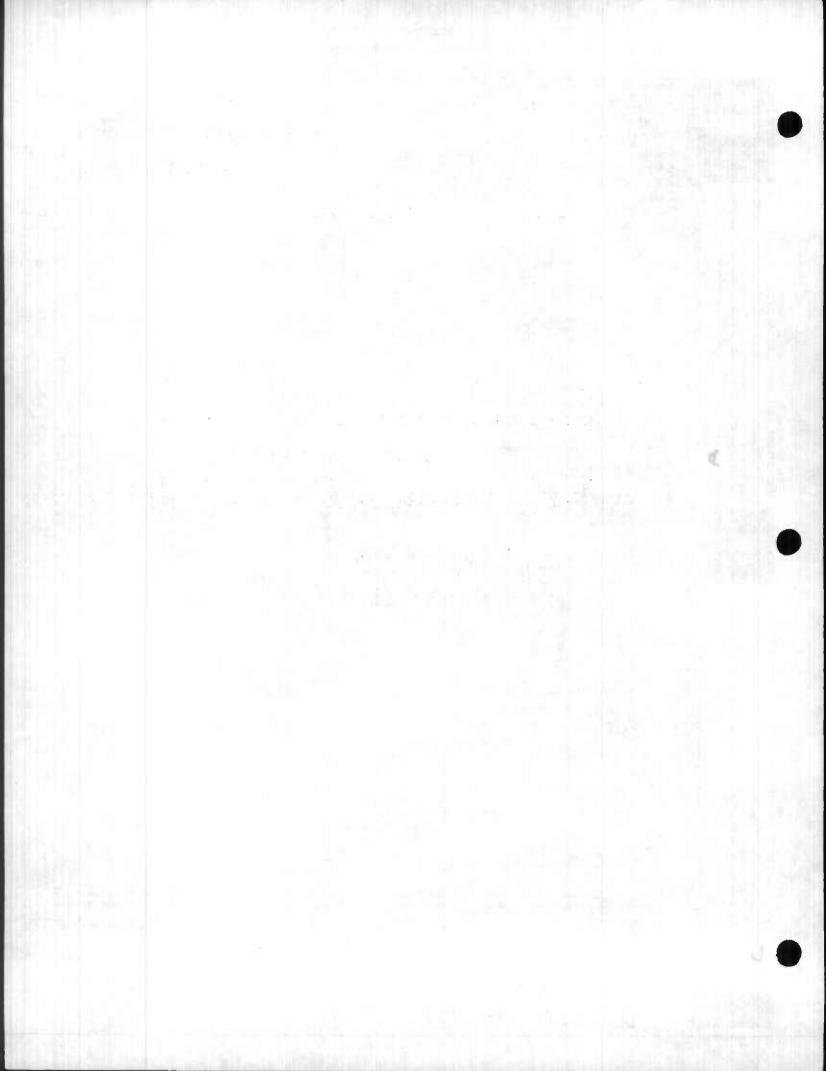
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31. Date filed (Month, Day, Year)



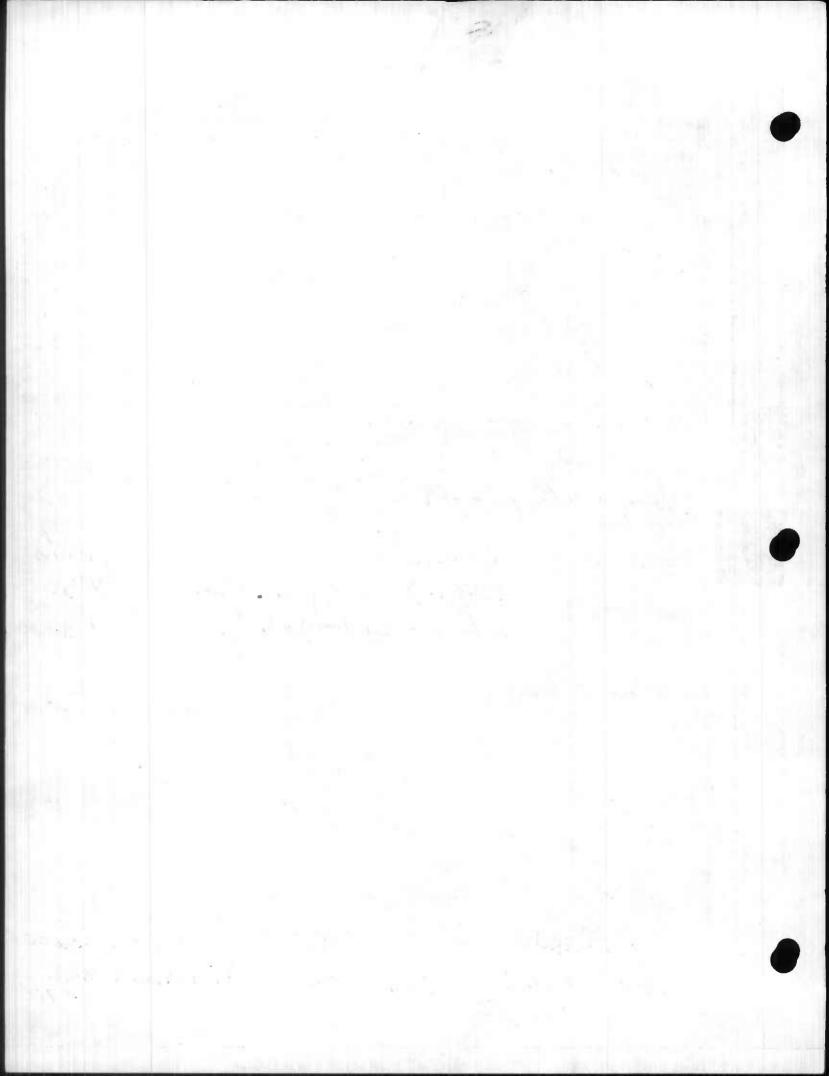
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				Certificate of L	Death	Reg. No.	72104					
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	Physician /Medical	PEARL	E. DORSEY		DEC		00   10:15 AM					
]	Examiner	4a Facility Nema (If not institution, giv			b. City, Town, or Location of							
_		Holy Cross Ho	_	1	Silver Spri	2	rgomery					
L	Funeral Director	5. Social Security Number 6. S  217-32-1677	7. Age (In yrs. last	Yrs. Months Days	Hours Min. Feb	of Birth th, Day, Year) .10,1930	9. Birthplace (Stata or Foreign Country) Penn.					
	Du Barre	10a. Stata 10b. County	10c. City,	Town or Location			10d. Inside City Limits					
	or 28s-f sh or 28s-f sh or notified	MD Montgo	omery	Silver Sprin	ng	10g. Citizan of V	1 Yas X No					
	death with the Maryler than 23s or 28s-f show that be notified at	3820 Bel Pre	•	2090		U.S.	.A.					
21215-0036	ors and Franch by Fu	11. Merital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2X No It Yes, Give Yaer or Datas:	1 ☐ Yas 2€ No			e - Americen Indian, k, White, etc. :: Black					
5-0		15. Decedent's Ed (Specify only highest gra	ducetion ida complatad)	16a. Decedant's Usual Occupa (Giva kind of work dona d tifa. DO NOT use retired)	Itlon luring most of working	16b. Kind of Bu	siness/Industry					
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lar		19a. Informant's Name/Ralationship (		19b. Mailing Addrass (Street a								
	s 1 and f Health tern 27 other tr	Barbara Herber		18161 Metz I								
Baltimore,	Int: If item	20a. Method of Disposition  1 □ Buriel 2 □ Cremetion 3 □  4 □ Donation 5 □ Other (Specification 1)		ce of Disposition (Nama of natary, cramatory or other place of Heaven			City or Town, Stata Ver Spring, MD					
Balt	Baltimo permit. Peges Department of Important: If is eny injury or page.	21. Signature V Funeral Service Liouv	Dion	22. Name and Address SNOWDEN	S of Eacility FUNERAL H	OME, P.A.	le, MD 20850					
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the daeth.				Approximate Infarval Batween					
E	Physician /Medical Examiner	Immediata Causa (Final disaase or condition rasulting in death)	Resp1	ratory P is e consequence oil; tatic	acture na Cana	rer	Onset and Death					
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	cartificate rector, peg	25. Was casa rafarred to medicel			26. Place of Death (Check	only one)						
>	0 0 0	examinar?	Hospital:	R/Outpatient 3 DOA Othe	97: 4□ Nursing Home 5□	Rasidence 6 Oth	ar (Specify)					
	r death. ector: Atter th by the funarai	27. Mannar of Death 1 Natural 5 Pending 2 Accident invastigation	28a. Date of Injury (Month, Day Year)	8b. Time of 28c. Injury Work	rat (? Yas 2 □ No	cribe how injury occur	red					
5	or Attending to a start death.  I Director: After led in by the funare  Certification:	3 Suicida 6 Could not b datarmined	28a. Place of Injury - At hom building, a(c. (Specify)	a, farm, street, factory, office		ation (Street and Numb or Town, Stata)	er or Rural Routa Number,					
	Funer float	29a. Cartifier (Check only one)  Continue 1 Certifying Ph	ysician: To the best of my knowledge:  Note: On the pasis of axamination and manner stated.	edga, death occurred at tha tim n end/or Investigation, in my op	a, data and place, and dua binion, death occurred at the	to the cause(s) and ma tima, date and place,	nnar as stated. and due to the cause(s)					
	within To the comple	29b. Signetura and life of certifier	J. Gens	29c. Licanse	54200	29d. Data signa	d (Month, Pay, Year)					
U		30. Mamb and address of person who	complated causa of death (Item)	Sa (Type, Print) 1500 Forest	Glen Rd,	Silvers	bring, MDgogi					
	State Registrar	31. Data tiled (Month, Day, Year) DEC 2.8 200	32. Registrar's Signatu	B. Sporks								



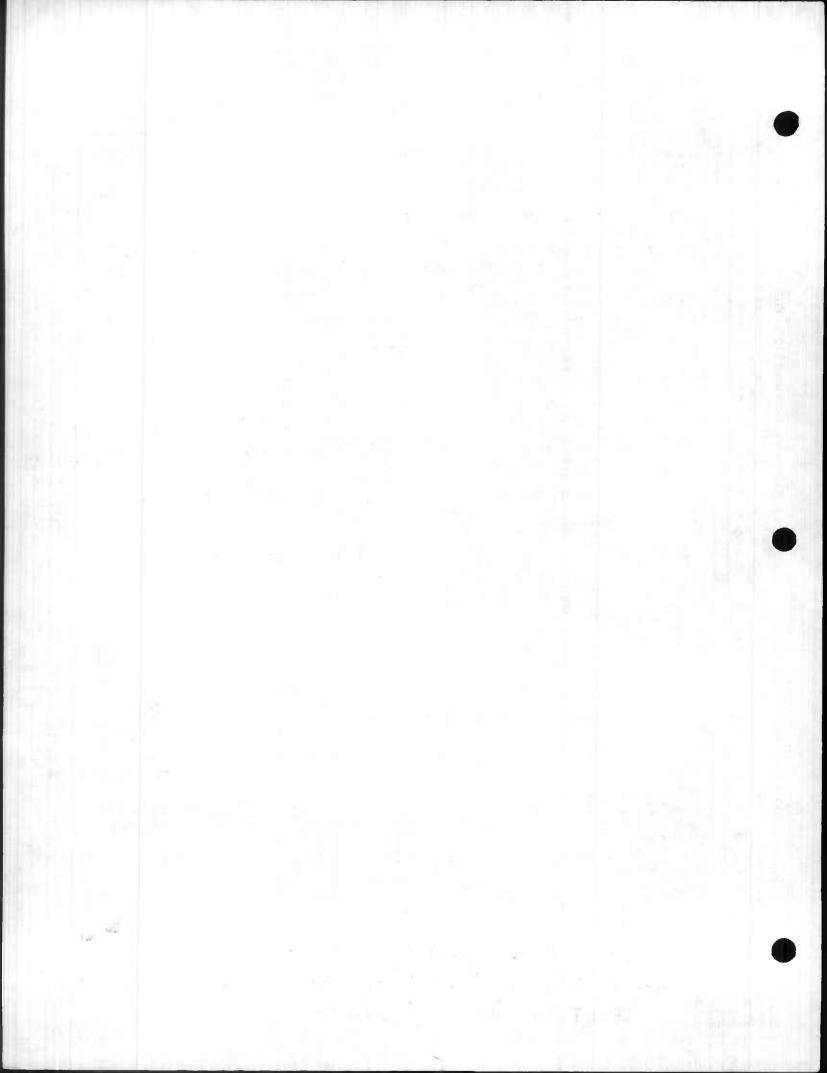
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month Dec. Physician Robert Α. 24, Diemer 2000 8:15P. /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Heritage Harbour Health & Rehabilitation Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day Year) 75 Yrs. Months Days Hours Min. August 7, 1925 5. Social Security Number 9. Birthplace (Stata or Foreign **Funeral** 1MM 2□ F Colorado Director 578-22-9354 Usual Residence of Deceder the Maryland 10a. Stata 10b. County 10c City Town or Location 10d. Inside City Limits Maryland Prince George's Beltsville 1 ☐ Yes 2 ♥ No Director 28a-f 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 5019 Olympia Avenue 20705 United States Norma 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 72 hours after 1 X Yes 2 No If Yes, Give 1943—1946 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: White Specify: þ 3 X Widowed 4 Divorced Pages 1 and 2 ahould be filed within 72 hours next of Health and Merkal Hygkens. wit: If Hearth and Tale mericed other than "naturals", and yo other trainmits event, the Medical East Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Lawyer Self employed 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Frank Diemer Josephine **DelDoso** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Roberta Diemer - Daughter same as #10 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata †2 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemetery 12/29/00 Cheltenham, Maryland 22. Name and Address of Facility Bonald V. Borgwardt Funeral Home, P.A. 21. Signature of Funeral Service Licensi 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata intarval Between Onset and Daath **Physician** /Medical Immediata Cause (Final MONIN emen disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner 01000 ician end burial-transit The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Box 68760. physician the buria Dua to (or as a consequence of) . for use signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records, p 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed pege 2 ( has certificate 1 Yes 2 N 1 ☐ Yas 2 ☐ No or Attending Physicien: 25. Was casa refarred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending invastigation To the Hospital or Attendit within 24 hours etter death. To the Funeral Director: A 1 Yes 2 No 2 ☐ Accident the 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At homa, larm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. 29e. Certifier Medical completely (Check only one) 29b. Signature and titla of certifier 29d. Data signed (Month, Day, Year) N. JanaKoh 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) beITRd 31. Data filed (Month, Day, Year) 32. Registrar's Signature State DEC 28 Registrar

DHMH 16 Rev 6/95



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	Certificate of Death Reg. No.											
Share in income	1. Decedent's Neme (First, Middle, Last)  2. Dete of Death Abouth Day Veer	Death										
Physician /Medical	Dorothy Delong December 35 3000 0.05	M										
Examiner	4e Facility Neme (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Deeth											
	WILSON HEALTH CARE GAITHERSBURG MONTGOMERY											
Funeral Director	5. Social Security Number 128 07 7297	Foreig										
fland # M	10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City	/ Limits										
th with the Maryle 23a or 28a-f sho set be notified at al Director	MD. MONTGOMERY GAITHERSBURG  100. Street and Number  100. Zip Code  100. Citizen of What Country?	2 🗆 No										
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OUZO ours after death v ranj, or items 23 Examiner must 1 by Funeral	3 ☑ Wildowed 4 □ Divorced Yeer or Detes: 1 □ Yes 2 ☑ No Specify: Specify: WHITE											
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	12 College (1-4or 5+) OFFICE MANAGER DENTAL											
Be well a	17. Fether's Neme (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)											
Menta Menta	EDWIN TROWBRIDGE THEODA STEVENSON											
de Send	19e. Informent's Neme/Reletionship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
4 5 5 5 5	EDWIN C. DeLONG SON 8446 SAND CHERRY LANE, LAUREL, MD. 20723  20e. Method of Disposition   20b. Plece of Disposition (Name of   Date   20c. Location - City or Town, Stete											
Pages 1 ment of He	20e. Method of Disposition  1 Buriel 2 Cremetion 3 Removel from State  4 Donetion 5 Other (Specify)  20b. Plece of Disposition (Name of cemetery, crematory or other place)  METROPOLITAN CREMATORY 12/26/00 ALEXANDRIA, VA.											
Demit Depart Import Imp	22. Signature of Funeral Service Licenses Barber P.O. BOX 5038, LAYTONSVILLE, MD. 20882											
	23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.	een										
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Onset and De 3 day  Due to (or es a consequence of):	sath .										
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12	December 21, 200  30. Name and postess of person who completed cause of deeth (Item 23a) (Type, Print)  JOHN R. MELLICK 911 RUSSELL ANE GAITHERSBURG, Md. 2007.	00										
	JOHN R. MELLICK 911 RUSSELL AVE GAITHERSOURG, Md. 2007.	9										
State	31. Dete filed (Month, Day, Year)  32. Registrer's Signeture											



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician Waitsel Daniels 28 2000 3:35 p.m. December. /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Montgomery Hospice Rockville Montgomery Hours Min. Nov. 2, 19 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral Days X M 20 F Months Yrs 238-30-3884 77 1923 North Carolina Director Usuel Residence of Deceden with the Maryland 10d. Inside City Limits 10a State 10c. City. Town or Location 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Examination initial be notified at 1 TYes 2 No Directo Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2003 Gainsboro Road 20851 United States Funeral death 12. Was Decedent Ever in U,S.
Armed Forces?

1 ₭ Yes 2 □ No
If Yes, Give
Year or Dates: WWII 14. Race - American Indien, 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after of Hygiene. other than "natural", or item 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 Tile Mechanic Construction 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) permit. Peges 1 and 2 should be filk Department of Heelth and Mentel Hy Important: if frem 27 is marked orth eny linjury or other treumatic event page. Be William Daniels Dora Jane Harrington 19a. tnformant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Maureen Daniels/ Wife 2003 Gainsboro Road, Rockville, MD 20851 Jan 2, 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) Silver Spring, MD Gate of Heaven Cemetery 2001 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Devol Funeral Home, 10 East Gaithersburg, MD 20877 TRACYA. c ture Gaithersburg, MD Deer Park Drive, 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final Renal Failure 3 Days disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examine Prostate Cancer Year The law requires that the death certificate be executed attending physicien and for use as the bunal-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) signed by the a 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown by 24b. Were eutopsy findings available prior to completion of cause of deeth? should should 24a. Wes en eutopsy Completed certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 X No Physician: director. 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify)Hospice Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA P 1 Yes 2 No this 28e. Date of Injury (Month, Dey Year) After this 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Certification: or Attending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte complately filled in by the fun 1 X Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner steted. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signatur 29c. License number D45880 December 28, 2000 5+1

Registra

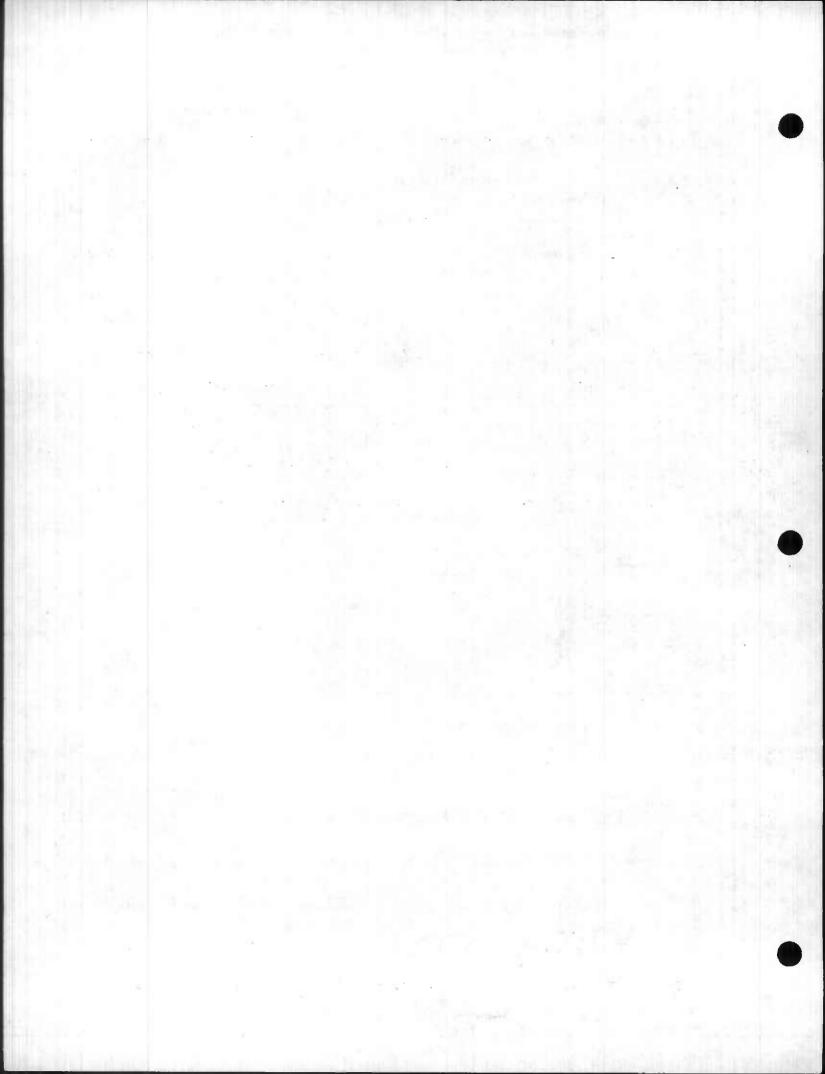
State

10400 Connecticut Avenue, #606, Kensington, MD 20895 Dr. Leon Hwang, 31. Dete filed (Month, Dey, Year) DEC 2 9 2000

32. Registrar's Signeture,

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

oaks



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Year HAZEL MARGARITE **EVERSOLE** December 27, 2000 7:20 A. M. 4a Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital & Medical Center Cumberland Allegany 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplaca (Stata or Foraign Country) 1□M 20 F Months 212-54-7897 84 Yrs. NOV 11 1916 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 √ Yes 2 No MARYLAND ALLEGANY CUMBERLAND 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 U.S.A. 511 REGINA AVENUE 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give A. Yaar or Datas: 14. Rece - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black, Whita, etc. 1 Naver Married 2 Merried 1 Yes 2 No Specify: Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER HOME MAKER 17. Fathar's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) CORA SARDINIA BOOR WINFIELD SCOTT ATHEY 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 13008 ELLERLIE ROAD N.W. CUMBERLAND MARYLAND 21502 DAUGHTER LAVERN McDONALD 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Steta 1X Burlal 2 Cremetion 3 Removel from Stete HILLCREST CEMETERY DEC 29 2000 CUMBERLAND MARYLAND 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name end Address of Fecility MERRITT-ADAMS FUNERAL HOME P.A. ents 404 DECATUR STREET CUMBERLAND MARYLAND a. Approximete Intervel Between Onsat and Death 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the moda of dying, such as cardiac or raspiretory errest, shock, or heart failure. List only one cause on each line. Immediete Cause (Finel disease or condition resulting in deeth) a. Pneumonia 3 days Due to (or es e consequenca of): b. Coronary Artery Disease 4 vears Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or es a consequenca of): Due to (or es a consequence of): resulting in daeth) Lest 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown 24b. Were eutopsy findings aveilable prior to 24a. Wes an eutopsy performed? completion of cause of deeth? 22 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) exeminer? exeminer? Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpetient 3 DOA

**Physician** /Medical Examiner

Examine

Physician/Medical

by

Completed

Be

To

Certification:

edicai

Manner of Death

Naturel

2 Accident

4 Homicide

3 Suicide

29a. Certifier (Check only one)

Dr.

31. Data filed (Month, Day, Year)

any ir

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Directo

Funeral

by

Completed

Be

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examination in this be notified at

permit. Pages I and 2 should be filed within 72 hours after or Department of Healin and Mental Hygiena.

The state of Healin and Mental Hygiena.

If it is marked other than "natural", or item in polarur if item 27 is marked other than "natural".

Baltimore, Maryland 21215-0036

with the Maryland

death

The law requires that the death certificate be executed attending physician and for use as the burial-trans 88 the signed by t been si certificate has page Physician: this After

Box 68760 Division of Vital Records, P.O. or Attending P burs after death. within 24 hours a

To the Funeral Completaly filled

> 5 ekc

State Registrar

29b. Signeture and title of certified

5 Pending investigation

6 Could not be determined

Vik Poonai

DEC 2 8 2000

30. Nema end address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signatura

merra

920 National Highway

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

LaVale, MD Docker

28c. tnjury at Work?

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated.

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29c. License number

1 Yes 2 No

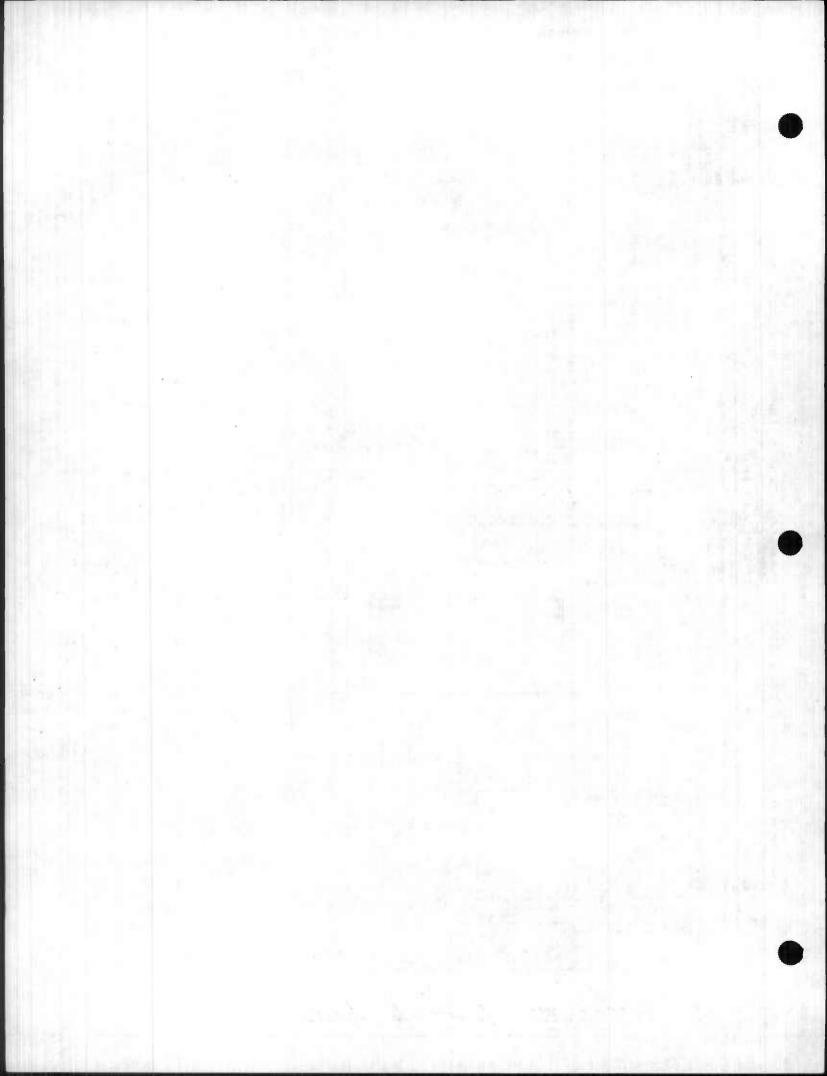
28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

December 27

29d. Date signed (Month, Dey, Year)

**DHMH 16 Rev 6/95** 



# Piease Type or Print in Black Indelible Ink. Assure Aii Copies Are Legible. 7 8 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month December 19 **Physician** 2000 12:10 AM Charles Franklin Fox /Medical 4b. City, Town, or Location of Death 4a Facility Name (# not institution, give street and number) 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick Birthplace (State or Foreign Country) If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Deys Min. Hours 10M 2DF Yrs. Director 82 220-34-7204 June 13, 1918 Virginia Usual Residence of Deceden the Marylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or hems 23s or 28s-f show 1 ☐ Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 11412 Daysville Rd. Funeral 21701 U.S.A.
Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Merital Stetus Black, White, etc. after 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: p 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) farmer dairy permit. Peges 1 and 2 should be filled v Department of Health and Mental Hygie Important: If Item 27 is marked other I any Injury or other traumatic event, II 17 Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles L. Fox Elvira Kindig 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) H. Irene Fox/ wife 11412 Daysville Rd. Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chapel Cemetery 12/21/00 nr. Libertytown, MD 21. Signature of Furneral Service License 22. Name and Address of Fecility any la Hartzler Funeral Home atharine yay 11802 Liberty Rd. Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that ceuse 1 in death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical STAGE .8AN Examiner Examiner MSLLITUS 13)38A1 UNKNOU death certificata be asscuted the attending physician and hed for use as the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or es e consequence of): 88 ed by the a 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. that the 1 Yes 2 No 3 Probably 4 Unknown signed t YM PHOMA Division of Vital Records, à requires 24b. Were autopsy findings aveilable prior to completion of ceuse of death? should l 24e. Was en autopsy performed? Completed TERIOSCUEROTIC CALDIO VASCULAR DUEASE WB DIERNS has page 2 VAJC The Theref 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata CORUNARY DUSEASE Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 25€No this After this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: or Attending P 5 Pending Investigation 1 Natural after death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 \ Homicide To the Hospital o within 24 hours af To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier dical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D10587 2000 MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 WEST 7th STREET, [AGDERICAL 14050 M.D. VICE PRES reolle 32. Registrer's Signeture 31. Date filed (Month, Day, Year) State

Registrar

DEC 2 7 2000

DEC 27 2000 James & from 15

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** 24 2000 14:40 **FESTERMAN** 12 RICHARD /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Memorial Hospital & Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | AUGUST 17 1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 9. Birthpiace (State or Foreign Funeral 1₹M 2□ F MARYLAND 74 Director 215-20-7416 Usual Residence of Decedent 10a. State r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nas 2 No ALLEGANY FROSTBURG Directo MARYLAND 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be. 21532 81 E. MECHANIC STREET U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates: W • W • II • Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 Nevar Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: À 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry filed within 7 Hygiens. College (1-4or 5+) Elementery/Secondery (0-12) GOLF COURSE **GROUNDSKEEPER** 18. Mother's Name (First, Middle, Maiden Surnema) 17. Fether's Name (First, Middle, Last) B should be is marked **FESTERMAN** BLANCHE HAWKINS WILLIAM 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 y of Health a A Bern 27 I 89 ARMSTRONG STREET, FROSTBURG, MD. 21532 WILLIAM FESTERMAN / BROTHER Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h Department of Important: If III any injury or o 1 Burial 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND CREMATORY DEC. 26,00 CUMBERLAND, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DURST FUNERAL HOME P.A. uch 57 FROST AVENUE FROSTBURG, MD 21532 23a Part. Enter the disease, or complications that ceused tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical day . Enterococcal bacteremia Examiner Due to (or as e consequence of) Examiner b. Cholecystitis, acute 30 days ettending physician and for use as the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Box 68760. Physician/Medical thet initiated events resulting in death) Last Due to (or as a consequence of): signed by the a d be detached t P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cirrhosis of liver by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peen Chronic obstructive lung disease certificata has pege 1 Yes 2 No 1 ☐ Yes 2 No of Vital Physician: Be 25. Wes case referred to medicat 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 10 1 Yes 25 No 1 inpatient 2 ☐ ER/Outpatienf 3 ☐ DOA this funeral 28b. Time of 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Attending ours effector: An Vin by the fur 1 Anaturel
2 Accident 5 Pending investigation 1 Tyes 2 No 6 Could not be determined 3 ☐ Suicida 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, streef, factory, offica building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours To the Funeral C completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D23334 DECEMBER 46, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINESH, B., SHAH, MD JOHNSON HEIGHTS MEDICAL BUILDING, CUMBERLAND, MD 21502 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State Registrar 27 2000

**DHMH 16 Rev 6/95** 

RICHARD FESTERMAN

Please Type or Print In Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month MALVINA TRIEDM 26 2000 2 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death MONTGOMERY 9704 INAUGURAL WAY GAITHERSBURG If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) Days Hours Months 1 M 2 F Yrs 92 1908 HUNGARY MAY 11, 057-32-4420 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6217 PLAINVIEW ROAD 20817 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puarto Rican, atc.) 12. Was Decedent Evar In U,S. Armed Forcas? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 TNo 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) TOBY "UNAVAILABLE" ELIAS MOSES 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6217 PLAINVIEW ROAD, BETHESDA, MARYLAND JUDITH BARTH/DAUGHTER 20b. Place of Disposition (Name of cemelery, cremetory or other place) 20a. Method of Disposition DEC 28 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. MORIAH CEMETERY 2000 FAIRVIEW, NEW JERSEY 21. Signature of Funeral Security Joenses 22. Nama and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) NEUMONIF Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or injury Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

attending physicien end for use as the buriel-trens

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page 2 a

certificate

After this funaral di

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To the Hospital within 24 hours a To the Funeral D completally filled

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or Attending Physician:

The lew requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Completed

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Certification:

edical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at

"natural",

os filed within 7 lai Hygiena.

permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier Important: if item 27 is marked other th any injury or other treumatic avent, the page.

Directo

Funeral

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Completed

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MD

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deeth with

72 hours after

Baltimore, Maryland 21215-0036

that initiated events resulting in death) Last

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 2 No

Hospital:

RTH

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 28c. Injury at Work?

26. Place of Death (Check only one) GROUP 4 ☐ Nursing Home 5 ☐ Residence 6 ②Other (Specify) HOME

28d. Describe how injury occurred

27. Menner of Deeth 1 Netural 2 Accident 3 Suicide

4 Homicide

5 Pending Investigation 6 Could not be determined

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 No

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Cartifier

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the cause(s) and menner steted.

29b. Signature and title of celtifie

29c. Licanse number

29d. Date signed (Month, Day, Year)

30. Nama and address of person w

completed cause of death (Item 23a) (Type, Print)

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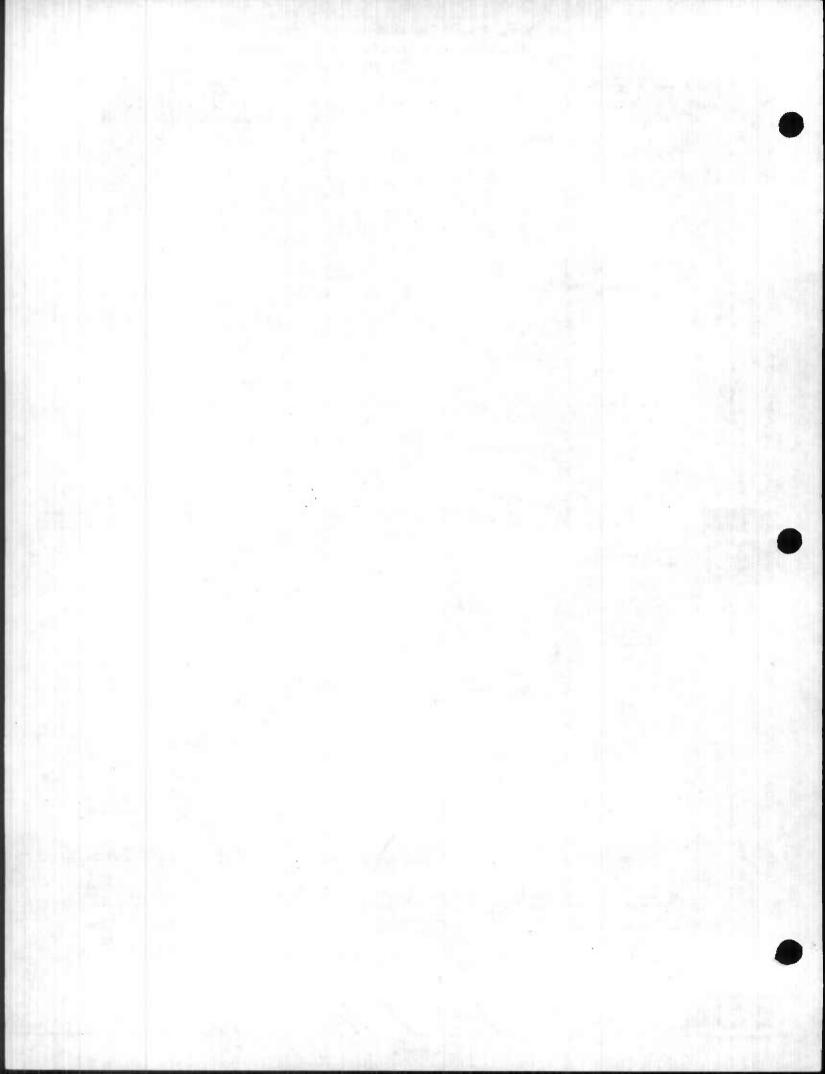
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31. Data filed (Month, Day, Year) **DEC 29** 2000 32. Registrar's Signatura

202

DHMH 16 Rev 6/95

Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Yaar **Physician** Pauline G. Floyd December 20, 2000 9:45 am /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare- Spa Creek Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Days Hours Min Yrs. 89 Director 578-24-3877 Aug 4, 1911 DC Usual Residence of Decedent Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Herns 23s or 28s-f show the Madical Examiner must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Annapolis the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 Harness Creek View Court Funeral 21403 death 12. Was Decedent Ever in U,S. Armed Forcas? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Black, White, etc. 72 hours after 1 Navar Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Nama (First, Middle, Last) Be 2 should be a la marked 2 Teresa O. Lederman John F. Grindle 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m sny injury or other traum once. 19 Harness Creek View Court, Annapolis, MD 2 ce of Disposition (Name of Date 20c. Location - City or Town, State William C Floyd / Son 21403 20b. Place of Disposition (Neme of cemetery, cremetory or other placa) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 12/23/00 Silver Spring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failura. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in deeth) arenery artery 4 years Examiner Due to (or as a consequence of) Examiner tha death certificate be axecuted signed by the attending physician and doe detached for use as the burial-transit Sequentietly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown requires that by 24a. Was an autopsy performed? Were eutopsy findings available prior to Completed completion of cause of death? The law his certificate has but director, page 2 s 1 ☐ Yes 2 No 1 Yes 2 No Physician: 25. Was case referred to medicat examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) aptal or Attanding Physic nours after death. neral Diractor: After this ce filled in by the funeral dire To 1 Yes 2 No 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending Investigation 1 Naturat 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Pteca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completaly filled 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai

State Registrar

20b. Signature and title of entities

Geet

31. Date filed (Month, Dey, Year)

Da

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signatura

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**DHMH 16 Rev 6/95** 

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Baltimore.

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Records,

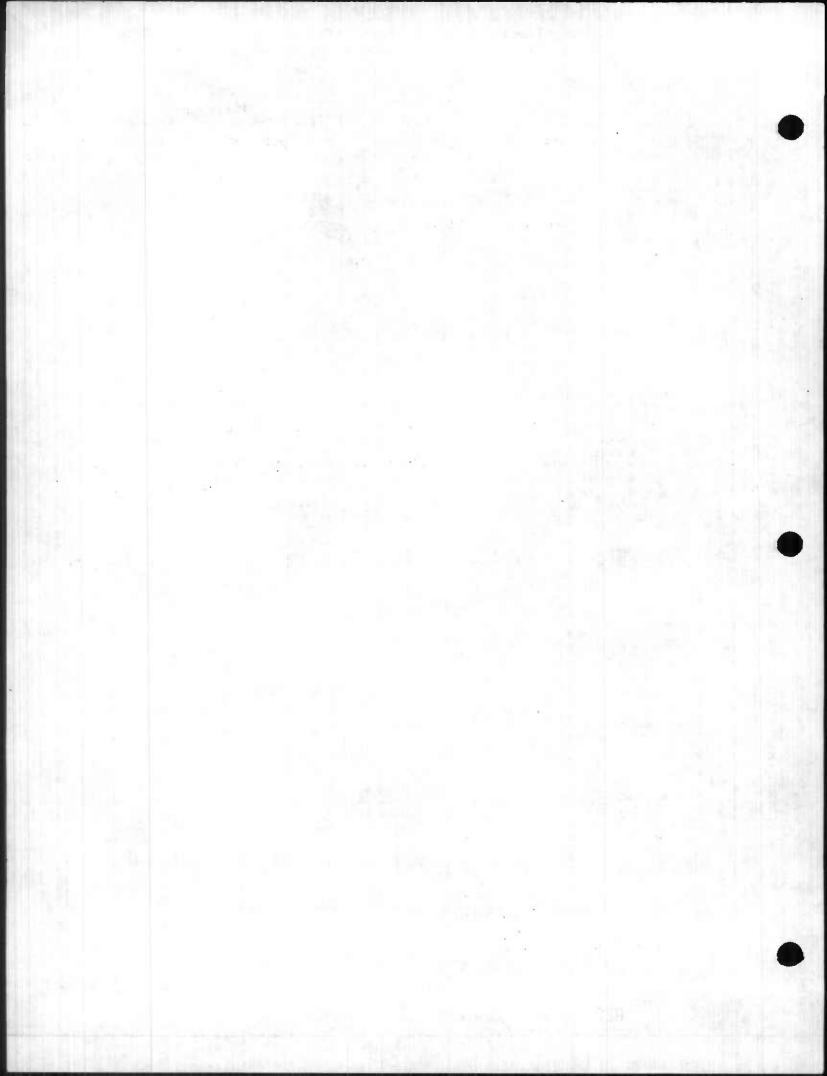
Division of Vital

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29c. License number

29d. Date signed (Month, Day, Year)

Road #106 oclenton MD 21113



State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death Month **Physician** THOMAS Μ. FITZPATRICK. JR. DECEMBER 23, 2000 9:30 AM /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner SILVER 2708 SPRING MONTGOMERY WELLER ROAD If Under 24 Hrs. If Undar 1 Yaar 8. Date of Birth MARCH Day 7 - 1952 Birthplace (State or Foreign NEW JERSEY 6. Sex. 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 48 213 60 3522 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MONTGOMERY Director SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20906 UNITED STATES 2708 WELLER ROAD \*natural\*, or items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11 Marital Status within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specity: п Yes, Give Year or Dates: Specify: WHITE à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 0 CLAIMS EXAMINER DEPT. OF LABOR 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middla, Last) Be 2 should be f end Mental } is merked THOMAS MICHAEL FITZPATRICK FELICIA MASTROMONICA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum page. ROBERTA SKAGGS-FITZPATRICK.WIFE 2708 WELLER ROAD, SILVER SPRING, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State NORBECK MEMORIAL PARK 12/28/00 OLNEY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
MURIEL H. BARBER FUNERAL HOME 21. Signatura of Funaral Service Licensee Darke P.O. BOX 5038, LAYTONSVILLE, 20882 Approximata Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** immediate Cause (Final disease or condition resulting in deeth) /Medical INTRA ABDOMINAL CARCINOMATOSIS 5 MOS. Examiner Due to (or as a consequence of):
METASTATIC ADENO CARCINOMA 5 MOS. Examiner the ettending physicien and hed for use as the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Box 68760. Physician/Medicai thet initiated events resulting in death) Last Dua to (or as a consequence of) 98 P.0. Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? detached 1 Yes 2 No 3 Probably 4 Unknown à been signed t Division of Vital Records. by 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed' 2.20 No 1 ☐ Yes 1 Yas 2 No this certificate 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 Yes 2 No P 27. Menner of Death 28a. Dete of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After Attending 5 Pending investigation 1 MNatural Injury death. 1 Yes 2 No 2 Accident or Attend after death Director: / filled in by the 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29d. Date signed (Month, Day, Year) 90. Sometime and titla of certifiar 29c. License number D23743 December 26, 2000 30

Registrar DHMH 16 Rev 6/95

State

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20770

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

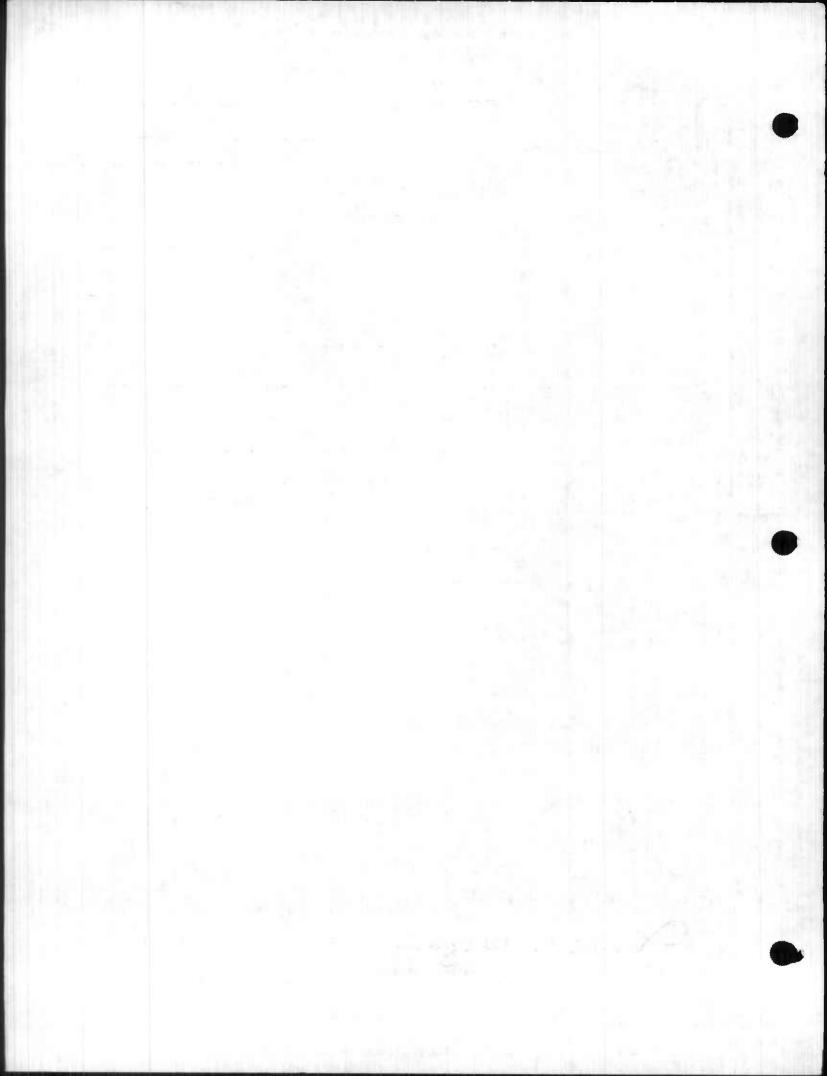
32. Registrar's Signature

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MARTIN O. WELTZ, M.D.

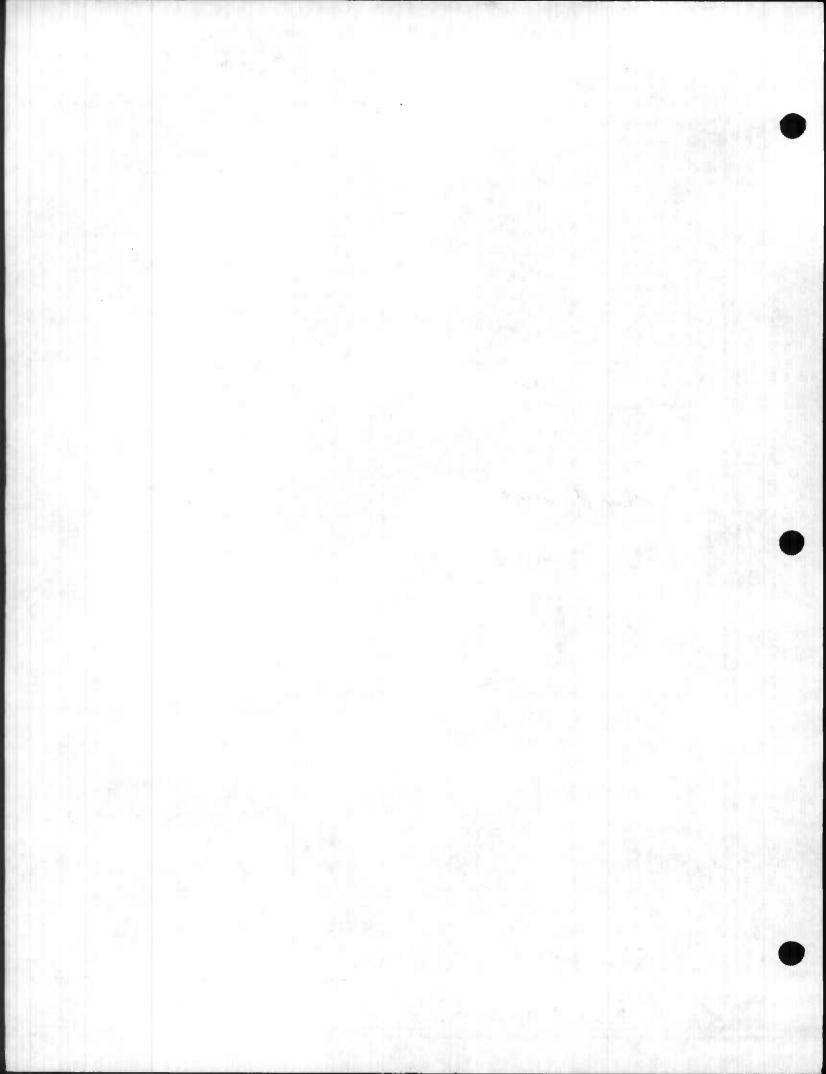
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27. Manner of Death 1 Natural 2   Accident 3   Suicide 4   Homicide  28a. Date of Injury 4   Month, Day Year)  28b. Time of Injury 4   Month, Day Year)  28c. Injury at Work? 4   Yes 2   No  28d. Describe how injury occurred  2	
29a. Certifler  29a. Certifler  (Check only one)  29a. Certifler  (Check only one)  29a. Certifler  (Check only one)  29a. Certifler  (Check only one)  29a. Certifler  (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner es stated.	ife Number,
29b. Signature end title of cartifier  29c. License number  29d. Date signed (Month, Dey, December 20, 20	cause(s)
30. Name end address of person who completed cause of death-(ffem 23a) (Type, Print)	cause(s)
Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 2	cause(s) Year)

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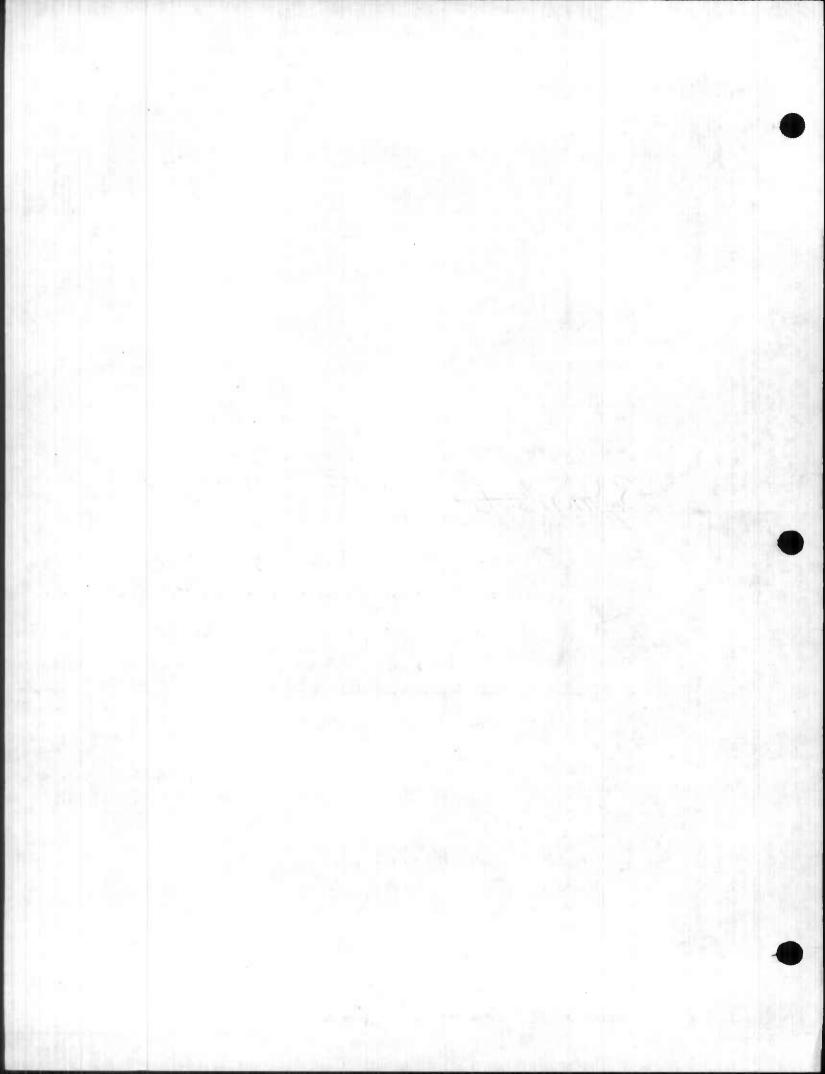


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vest **Physician** Edna Ruth Farrell DECEMBER 26 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Months 1□ M 25 F Feb. 13, 1915 85 Yrs. 218-38-6472 Mary land Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a Stete 10b. County 10c. City. Town or Location Greenbelt 1 X Yes 2 □ No Prince George's Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or hema 23s or the Medical Examiner must be a 20770 402 Ridge Road, #7 United States Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX o If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) Housewife own home is marked other 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 2 and Mental Clarence Wilmer Dollie Elizabeth Sisson Thompson and 2 should 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. informant's Name/Reletionship (Type, Print) of Health a Item 27 is Charles Farrell - son 442 Ridge Road, #2 Greenbelt, Maryland 20770 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Pages 8 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Metropolitan Crematory 12/28/2000 Alexandria, Virginia 21. Signature of Poneral Service Licensee 22. Name and Address of Facility Donald V. Bordwardt Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or tream failure. List only one cause on each line. 4400 Powder Mill Rd. Beltsville, Maryland 20705 Approximate interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical CKRD10-RESPURATORY Examiner Due to (or as a consequence of): Examine appopula Oh Manch attending physician and for use as the bunal-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest CAMPAIC P.O. Box 68760. ONS PLUCTUS Physician/Medical Due to (or es e consequence of): WTRECTION Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 2 signed b Division of Vital Records. p 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy CARNOVARRAM has 78 2 9080 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medicel 26. Place of Death (Check only one) Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28c. injury at Work? 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Watural 2 Accident 5 Pending investigation 1 Tyes 2 No death. eral Director: / 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral C completely filled 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print) MAN HOW JUTOR - SOUSIN PA. m) - 132 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

**DEC 29** 

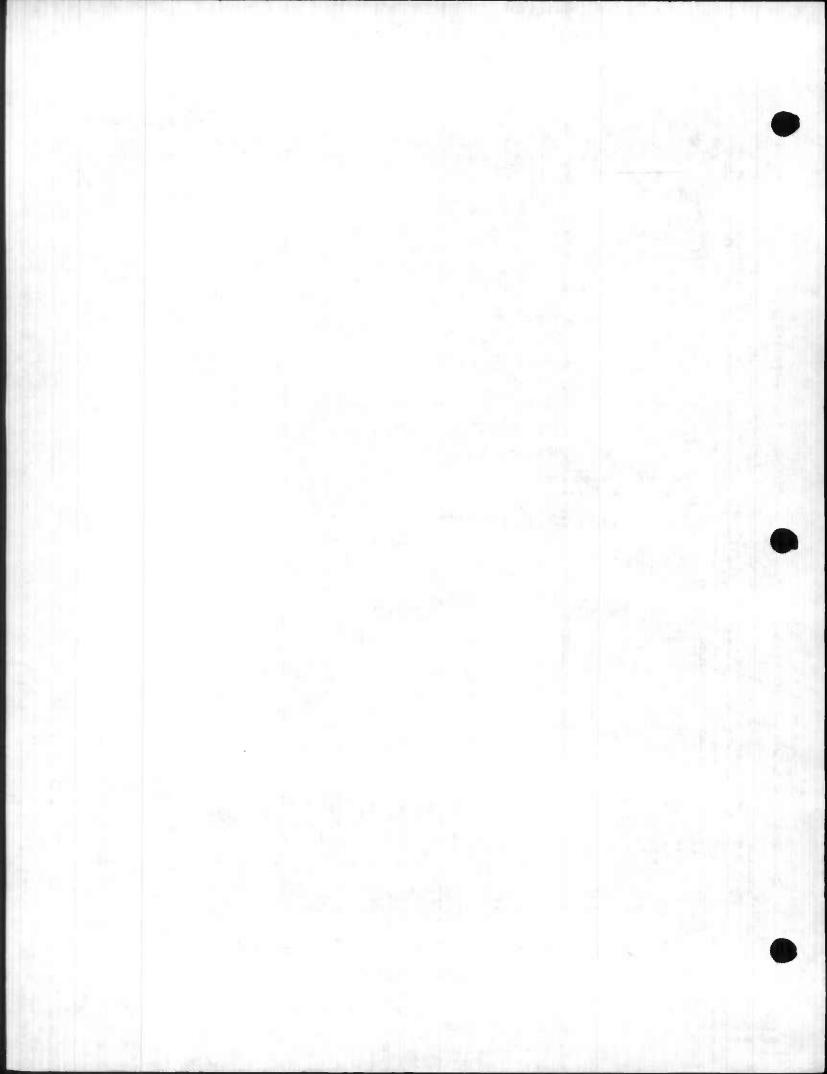
2000



State of Maryland / Department of Health and Mental Hygiene amend item 5 per fh G791 1/23/01 yf Certificate of Death 2. Data of Death 1. Decedent's Neme (First, Middle, Last) 3 Time of Death Day 28, Month 2000 **Physician** 9:00 AM Jacqueline Patricia Gearheart December /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death Examiner 1105 Princeton Lane Waldorf Charles Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 19, 1931 9. Birthplece (Stete or Foreign **Funeral** Yrs Washington DC Feb. 69 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylar Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or frame 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be motified at 1 Yes 2 No Directo Charles Waldorf Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20602 1105 Princeton Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be William Brieling Cleo Lewis 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 11110 Country Road, Dunkirk, MD 20754 Kathy A. Scaldaferri-Daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 N Buriat 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans' Cem. 1-3-01 Cheltenham, MD 22. Name and Address of Eacility
Huntt Funeral Home, Inc. 23a. Partl. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P. O. Box 156, Waldorf, MD 20604-0156 Approximata Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Colon Cancer with metastasis diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examine Sequentially list conditions, if any, leeding to introduct cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the buna Box 68760 lan/Medical Due to (or as a consequence of) Physici D.O. Part II. Other afgnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 | Yes 2 | No 3 | Probably 4 | Unknown p Division of Vital Records. 8 24b. Wara autopsy findings Completed 24a. Was an autopsy available prior to completion of ceuse of deeth? performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes XXXX 25. Was cese referred to medicel Be 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home XX Residence 6 Other (Specify) 1□ Yes 2XXXX 0 this 27. Menner of Deetl 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Attending 5 Pending investigation death. 1 Yes 2 No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours at To the Funeral DI 1 Carifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Licanse number 29d. Data signed (Month, Dav. Year) 26064 V. Mmai December 28, 2000 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Anmangandla Vidyasagar, MD., P.O. Box 282, Charlotte Hall, MD 20622 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 2 9 2000

DHMH 16 Rev 6/95

Registrar



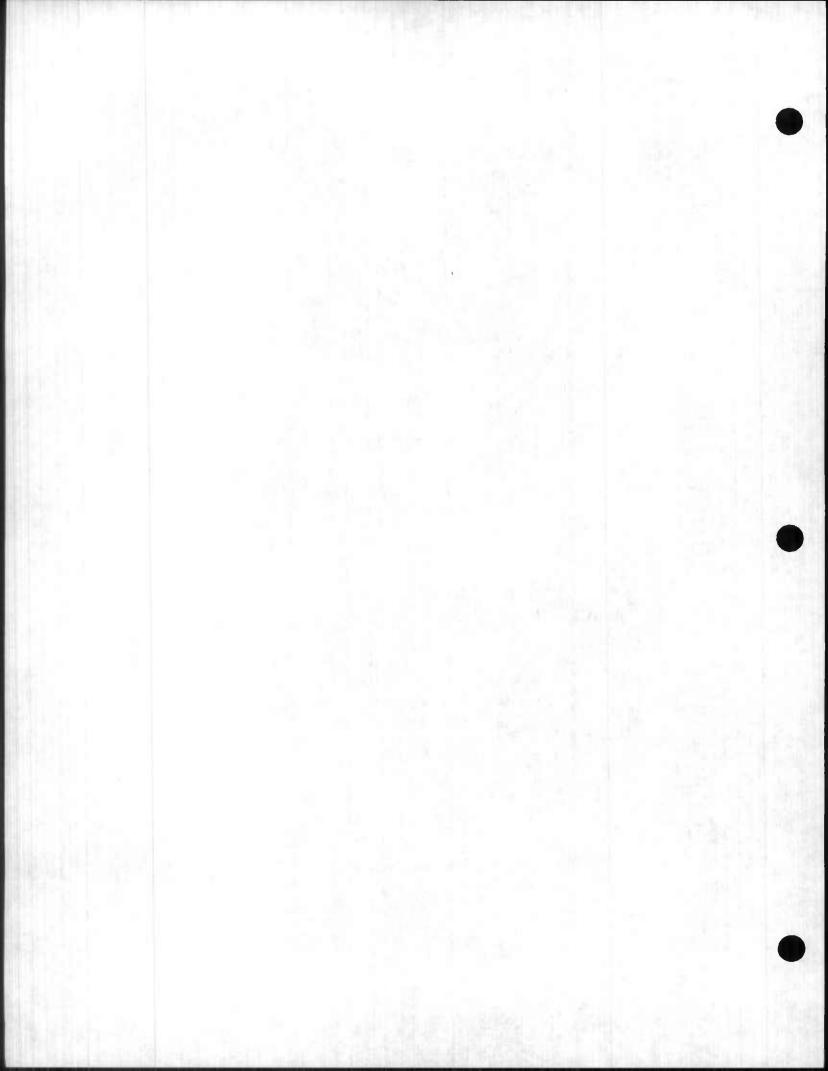
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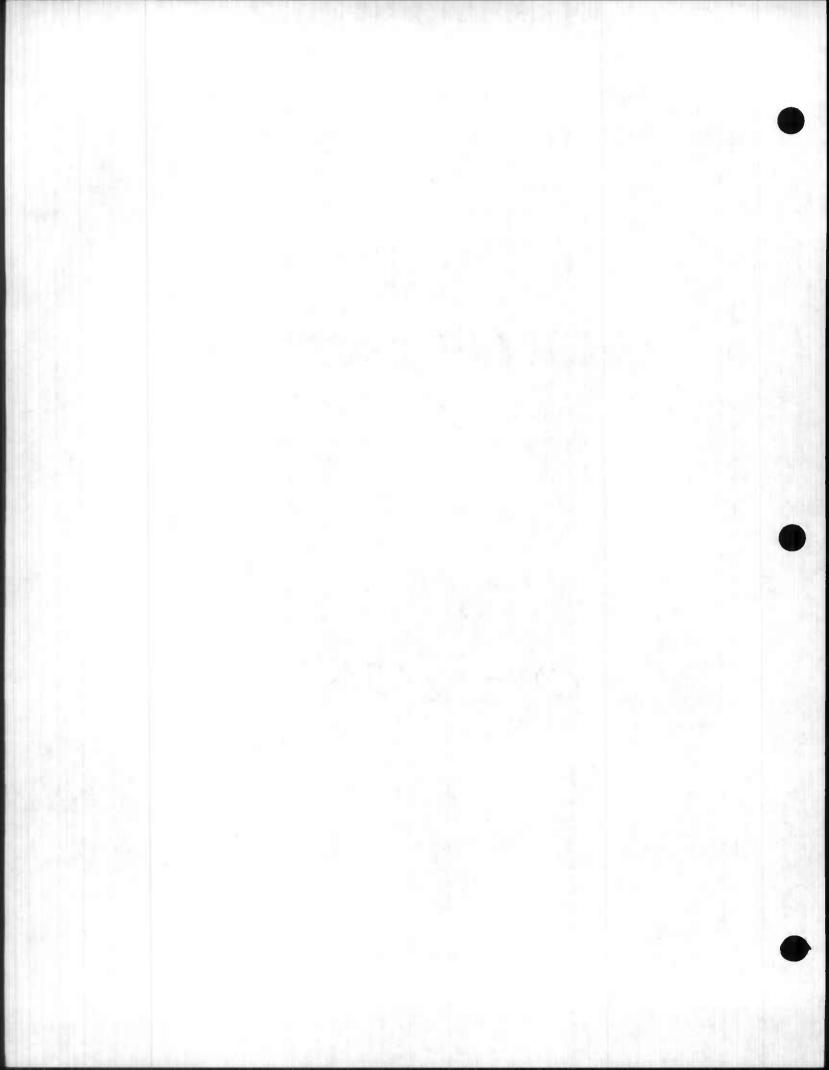
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01-05/33



# VOID CERTIFICATE ## 30-42798

SEE CERTIFICATE M 01-01366



Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death **Physician** DECEMBER 2000 LYNN GREEN 12:20 a.m. KAREN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fscility Name (If not institution, giva street and number) Examiner **ALLEGANY ECKHART** 10601 LAUREL HILL S.W. If Undar 24 Hrs. B. Date of Birth If Under 1 Year 5. Sociel Security Number 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1□ M 2☑ F Months Days 19,1948 MARYLAND 52 220-52-9590 Yrs. NOVEMBER Director Usuai Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location 28a-f show ed other than "natural", or itema 23a or 28a-f showevert, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo FROSTBURG MARYLAND ALLEGANY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21532 U.S.A. 17500 OLD NATIONAL PIKE S.W. permit. Pages 1 and 2 should be filed within 72 hours effer death a Department of Health and Mentel Hygiene, important: If item 27 is marked other than "natural", or flams 28 and hijury or other traumatic event, the Health Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Datas: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, spacify Cuban, Maxican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by 3 ☐ Widowed 4 DXDivorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Elementery/Secondary (0-12) College (1-4or 5+) OFFICE CLERK STATE OF MARYLAND 12 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fathar's Nama (First, Middle, Last) Be RANKIN BETTY RIZER WALTER LEE 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) SHARON GARRISON / SISTER 10601 LAUREL HILL S.W. ECKHART, MARYLAND 21528 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 ☐ Buriei 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CUMBERLAND CREMATORY DEC 24,2000 CUMBERLAND, MARYLAND 22. Name and Address of Fecility DURST FUNERAL HOME P.A. 21. Signature of Funeral Service Licens 57 FROST AVENUE FROSTBURG, MARYLAND 21532 23a. Part. Enter the disease, or complications thet caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Metastatic Carcinoma of Colon 9 months Examiner Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be asscuted Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or es e consequence of): ng physician a Box 68760. thet initieted events resulting in death) Lest Due to (or es e consequence of): esn P.O. Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? datached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 ρ Division of Vital Records. 24b. Were eutopsy findings available prior to completion of cause of death? page 2 should Completed 24a. Was en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completaly filled in by the funerel director; 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Sister's 1 Yes 2 No Medicai Certification: To 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred house 5 Pending investigation 1 X Naturei 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier 29b. Signeture and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) ssur M1. D21244 December 24, 2000

Registrar

State

FROSTBURG, MARYLAND 21532

FROSTBURG PLAZA

32. Registrar's Signeture

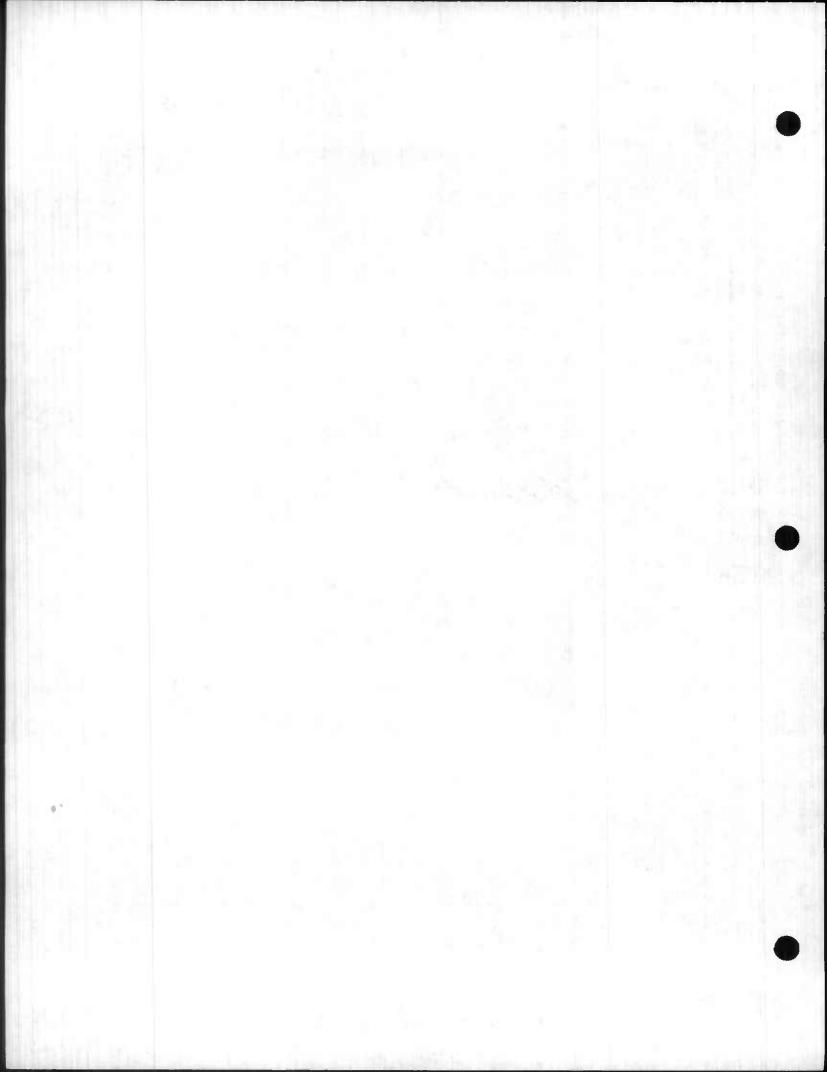
30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

TAN

Dr. JESUS H.

DEC 29 2000

31. Dete filed (Month, Day, Year)

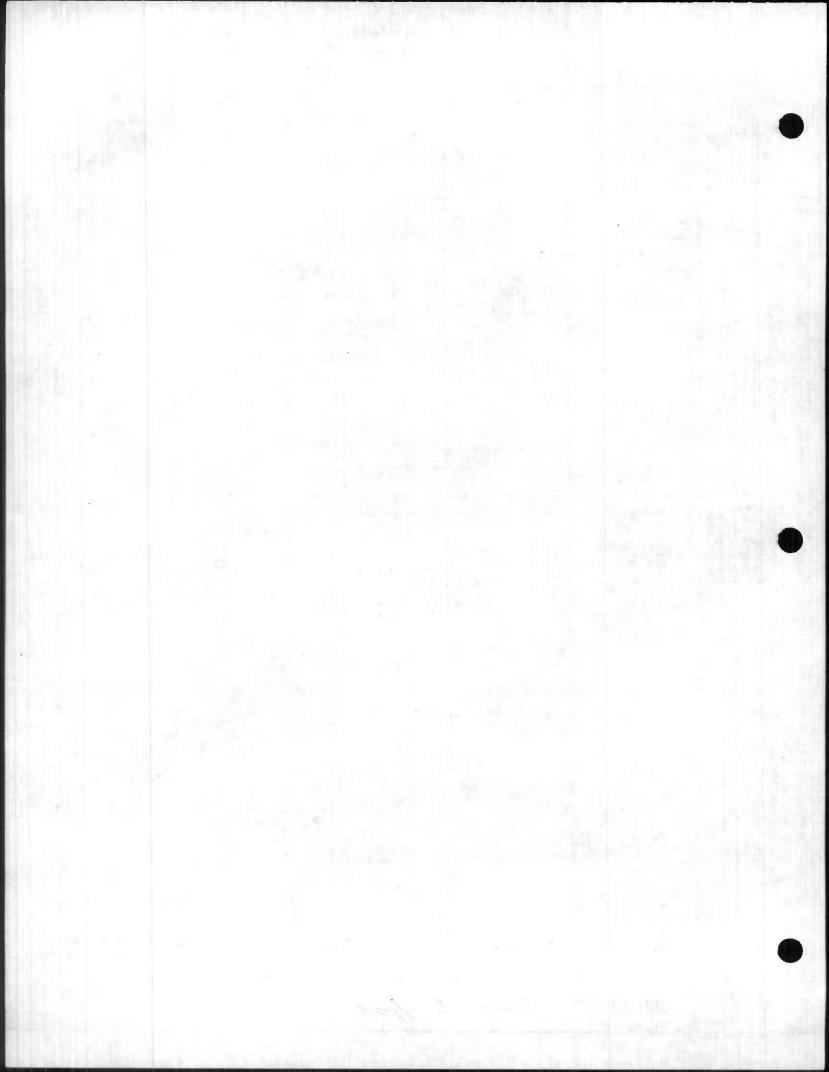


State of Maryland / Department of Health and Mental Hygiene 0 1, 2800

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Exami	ner	Memorial Hospi			Center			perland		legany		
Funeral Director		5. Social Security Number 219-42-7346	s. last birthday Yrs.	Months Days Hours Min.			of Birth Day Year) 6 1946	9. Birth MAR	placa (Stata or Foraign nto) YLAND			
urs after death v at', or thems 23s Examiner must		Usual Residence of Decedent  10a. Stata 10b. County		10c C	City, Town or L	ocation					10d. Insida City Limits	
	Director	MARYLAND ALLEC	GANY	100.0	CUMBE	RLAND					1  Yas 2 No	
		10e. Street and Number 212 CHARLES STRI	FFT			10f. Zip Coda 2150	2			of What Cou	ntry?	
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		23a. Part1. Enter tha disaasa, or c	omplications that	caused the dec	ath. Do not er					MARILA	Approximata Intarval Batween	
Physician	н	shock, or heart failure. List only one cause on each line.										
/Medical Examiner		Immediata Causa (Final disaasa or condition	S	epsis						1		
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/		1	5 MD			D549	946		DECEME	BER 28,	2000	
This		30. Nama and addrass of person w Dr.Boyd Sprenkle		sa of death (Ita emorial	am 23a) (Type Ave St	Print)	Cumber	land, MD	21502			
	ate	31. Data filed (Morith, Day, Year)	32.	Registrar's Sign	giture /	parks/					4.77	
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Registrar



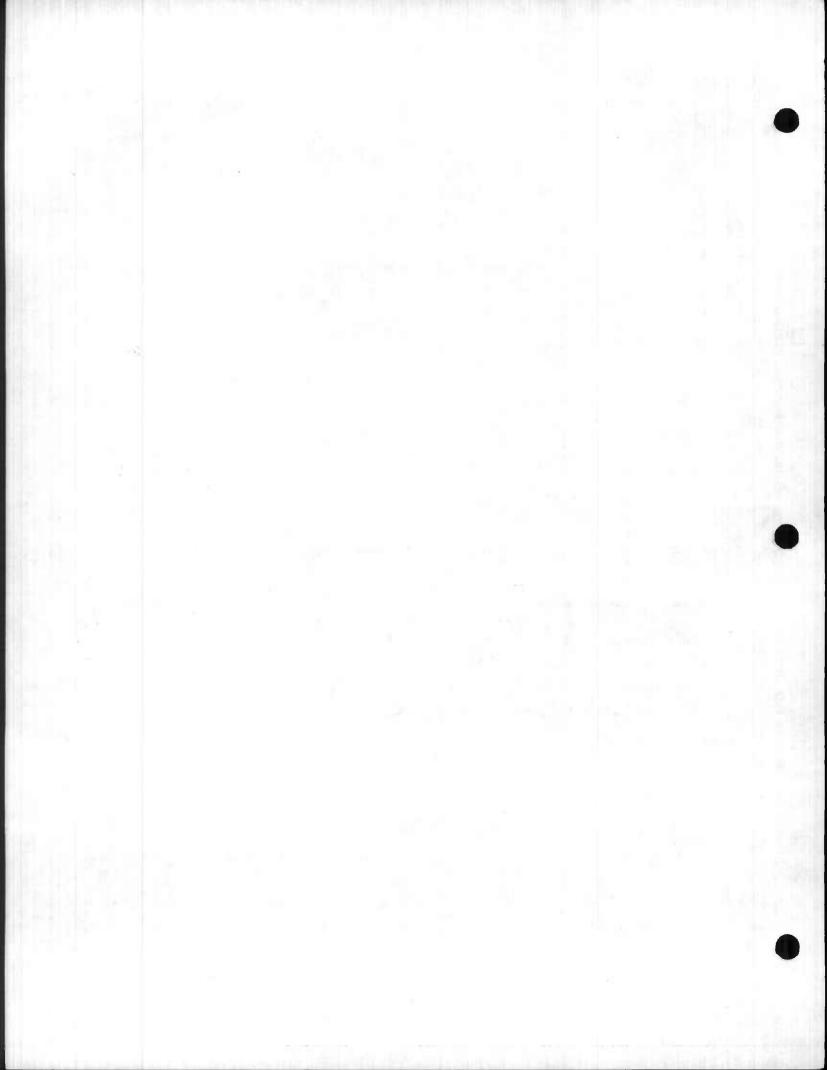
Piease Type or Print in Biack Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 9:15 An December Li - Yu 2000 21 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 2Q F 578-23-4326 Yes 46 Director September 15,1954 China Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Crucible Court 21108 China death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Bleck, White, etc. 11. Meritel Status filed within 72 hours after 1 Never Married 2 Merried 1 Yes 2X No If Yes, Give Yeer or Detes: 21215-0020 1 Yes 2€ No Specify: Asian Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Baltimore, Maryland permit. Peges 1 and 2 should be file Depertment of Health and Mental Hy Important: If flem 27 Is marked ortherny Injury or other treumatic avent state. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Guo Qi Tai Zhang E. Yang 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 615 Crucible Ct. Millersville, MD 21108
page of Disposition (Name of Date 20c. Location - City or Town, State Qin Chen / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State George Washington 12/28/00 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHines-Rinaldi Funeral Home, Inc. 21. Signeture of Floreral Service Licensee 11800 New Hampshire Ave Silver Spring, MD 20904 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, nly one cause on each line. 23a. Parl1. Enter the disease shock, or heart feilure. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760, Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the a 1 Yes 2 No 3 Probably 4 Unknown Records, P 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours aftar deeth. Funeral Director: After this certifice 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient edical Certification: To 1 Yes 2 ER/Outpatient 3 DOA 27. Menger of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29e. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 21 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), 30) Hayaran Signature 301

Registrar

State

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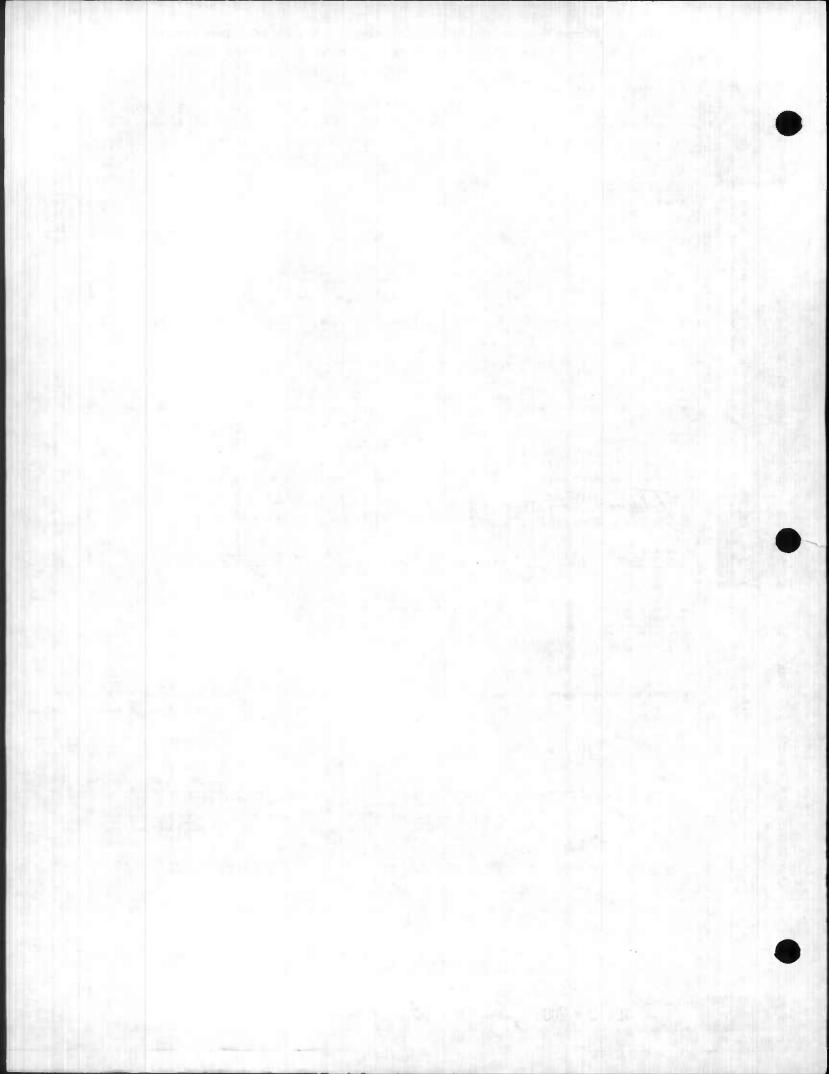
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 0 1 2 8 0 2

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land.	Funeral	5. Social Security I		. Sex	7. Age (In yrs.	last birth	Months	er 1 Year s Days		4 Hrs. 8. Dete	of Birth oth, Day, Y	ear)	9. Birth		e or Foreign
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Maryland 21215-0020	od N od N	19a. Informant's N	lame/Relationship	(Type, Print)	No.	19b. I	Mailing Addre	ss (Stree	t and Number	or Rural Route	Number, C	City or Town	, State, Zij	Code)	
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1 = i	M India	21. Signature of F	uneral Service Lic	ansee			22. Name	and Addre	ess of Facility	Joseph	Gaw1	er's S	Sons		
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P	Physician	shock, or heart failure. List only one cause on each line.  Onset end Death													
	/Medical	Immediate Cause (Final My OCAP N/AL INFAP CITION 5 DAVS													
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	Affect funeral lon:	27. Manner of Dea 1 Matural	th 5 Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Ti	jury	28c. Inju			scribe how	injury occu	rred		
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Beck Divisi	as of Attending Programmers and Director: After the din by the funeration:	4 Homicide	determine	286. Plac	a of Injury - At hi ding, etc. (Speci	nome, farr ify)	m, street, facto	ory, office		28f. Loc City	or Town,	et and Nurr State)	iber or Hui	al Houle N	umber,
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	n 24 hours no Funeral pletely filled edical Co	29a. Cartifier (Check only one)	2 Medical Ex	Physician: To the aminsr: On the I	basis of examina	ation and	death occurre for investigation	on, in my	opinion, death	place, and due h occurred at th	e time, date	se(s) and m and place	anner as , and due	stated. to the caus	e(s)
	Se de de	29b. Signature and	title of ceptifier	and mai	nner stated.	1	/ 2	9c. Licen	se number		290	I. Date sign	ed (Month	, Day, Year	r)
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		30. Name and add	ress or person wh	o completed cal	ise of death (Ite	m 23(1) (1	Mow	TPO	10 1	al Ro	cki	1/6	Ma	171	2000
	Cana	31. Date filed (Mor	nth, Day, Year)	32	Begistrar's Sign	ature	1-1000	1 20.	1	4 / 0	CIO	117	, - / U	~ (	1002
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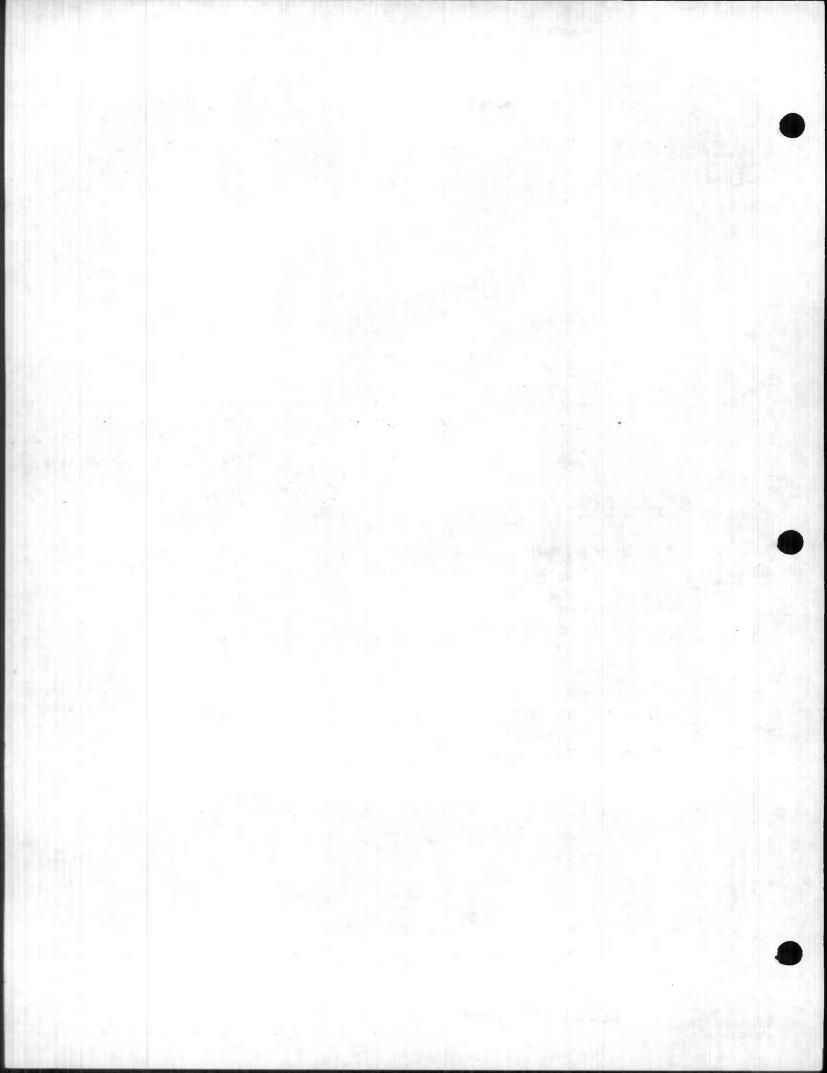


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State of Maryland / Department of Health and Mental Hygiene

		Certificate of De		803									
	Physician	Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Year	3. Time of Death									
	/Medical	HOPE DELIGHT MURRAY GRAY		11:30 AM									
	Examiner	4a Facility Name (If not institution, give street and number) 4b. C	ity, Town, or Location of Death 4c. County of Death										
		TIGHTOT OUTO DOTHER	thesda Montgomery										
	Funeral	Months Devs H	Under 24 Hrs. 8. Date of Birth 9. Birthple ours Min. (Month, Day, Year) Count	ace (State or Foreign									
	Director	027-22-5940 94 Yrs.	Mar. 26, 1906 Kans										
	5	Usual Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location	16	d. Inside City Limits									
	ahow			1½ Yes 2 □ No									
	the Maryla 28a-1 sho notified	MD Montgomery Kensington	10.000										
	or Son	10a. Street end Number 10f. Zip Code	10g. Citizen of What Count	ry?									
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		11. Men'tal Stetus  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispar	nlc Origin? (Specify Yes or No- laxican, Puerto Rican, etc.) 14. Race - America Black, White, e										
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5		15. Decedent's Education (Specify only highest grade completed) (Give kind of work done durin life. DO NOT use retired)	ng most of working	ustry									
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an	0 5 0 0		Ethyl McKinsie										
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Maryland	d2 s th an 7 is trau												
	ges 1 and 2 should t of Health and Mer if Item 27 is marke or other traumatic	20a Method of Disposition 20b, Place of Disposition (Name of	Date 20c. Location - City or Tox										
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I	그 문문을	4 Donation 5 Other (Specify) National Crematory  21. Signature of Funeral Serger Licenses 22. Name and Address of	12/27 Falls CHurch	, VA									
Ba	Department of many is	JOSEPH GAWLE	R'S SONS, INC.										
	-			DC 20016									
п		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart tailura. List only one cause on each line.	uch as cardiac or respiratory errest,	Approximate Intarval Between Onset end Death									
	Physician /Medical												
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of	\$ 2 mm →	To Tes 240 To The Inpatient 20 Eryoutpatient 30 DOA	4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28d. Dascribe how injury occurred	"									
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Division	tal or Attanding P is after death.  al Director: After the in by the funeral Certification:	4 Homicide building, etc. (Specify)	City or Town, State)										
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	n 24 hou n 24 hou we Funer pietely fii	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	on, death occurred at tha time, date and placa, and due to	the cause(s)									
	To the Hospital or Atlandi within 24 hours efter death. To the Funeral Director: A completely filled in by the it.		mber 29d. Date signed (Month,	Day, Year)									
	- > - 0	D3557	December 26,	2000									
	6	30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)	December 20,	2000									
		So. Herrio and address of person who completed cause of death (Rain 238) (Type, Frint)	D -11- WD 20016										
		Cucan T Millor M D 69// Tulin Hill Towns	RAFTHAGUAL MILL ZUALD										
	State	Susan J. Miller, M.D. 6844 Tulip Hill Terrace  31. Date filed (Month, Day, Year)  32. Registrar's Signature  DEC 2.9 2000	ee Bethesda, MD 20816										

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death **Physician** Lucille Charles Gotthardt December 12, 2000 11:04 PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery If Undar 1 Yaar 5. Social Security Number 6. Sex If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Oct. 20, 1 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1□M 2⊠F Months Days Hours Min Yrs. 89 064-07-8083 Georgia Director Usual Rasidanca of Decedant the Maryland 10a Stata 10h County 10c. City. Town or Location 10d. Inside City Limits rail, or itams 23a or 28a-f show Examiner must be notified at 1 ☐ Yas 2 € No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 15301 Pine Orchard Drive, #35 20906 USA death Funeral 12. Was Decedanf Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian. Black, Whita, atc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 natural, or 1 Yas 2 No Specify Specify: White by 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona duning most of working lifa. DO NOT use retired) 16h Kind of Businass/Industry should be filed within and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home other 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) h end Mental h Charles Nix Inez Lillias House Clark 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) permit. Pages 1 and 2 st Department of Hasith en Important: If Item 27 Ian any Injury or other traus Joan Gotthardt / Daughter 2505 Camberwell Court, Herndon, Virginia 20171 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) National Memorial Park 12/15/00 Falls Church, Virginia 22. Nama and Addrass of Facility Hines-Rinaldi Funeral Home 21. Signatura of Funaral Service Licensas 11800 New Hampshire Avenue Silver Spring, Maryland Part 1. Enter tha disages, or complications that ceused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsaf and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Examine Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated avents rasulting in death) Last attending physician end for use as the bunkl-trar that the deeth certificate be execut carclas P.O. Box 68760 GROTION Physician/Medical Dua fo (or as a consaquance of) WS ed by the a 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions confributing to death but not ratural in the underlying of signed by t 1 Yes 2 No 3 Probably 4 Unknown 00 Division of Vital Records, à 22 24b. Wara autopsy findings available prior to complation of causa of death? should I 24a. Was an autopsy performed? Completed page 2 s 1 ☐ Yas 1 Yas certificate Physician: director. Be 25. Was cesa referred to medical 26. Place of Death (Check only ona) examinar? Hospital: Othar: 4 Nursing Homa 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Rasidence 6 Othar (Specify) this 27. Mannar of Death Data of Injury (Month, Day Year) 28b. Tima of Injury 28c. Injury at Work? 28d Dascribe how injury occurred Certification: After To the Hospital or Attending 1 Dyatural 5 Panding Invastigation Unknowh 1 Yas lost Accident 100 ETIPH 7 Ja lance Director: / 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) aftar 4 | Homicide GIANT Fouch 3% o Internation Opine within 24 hours af To the Funeral DI completaly filled in Mary lane Olney Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

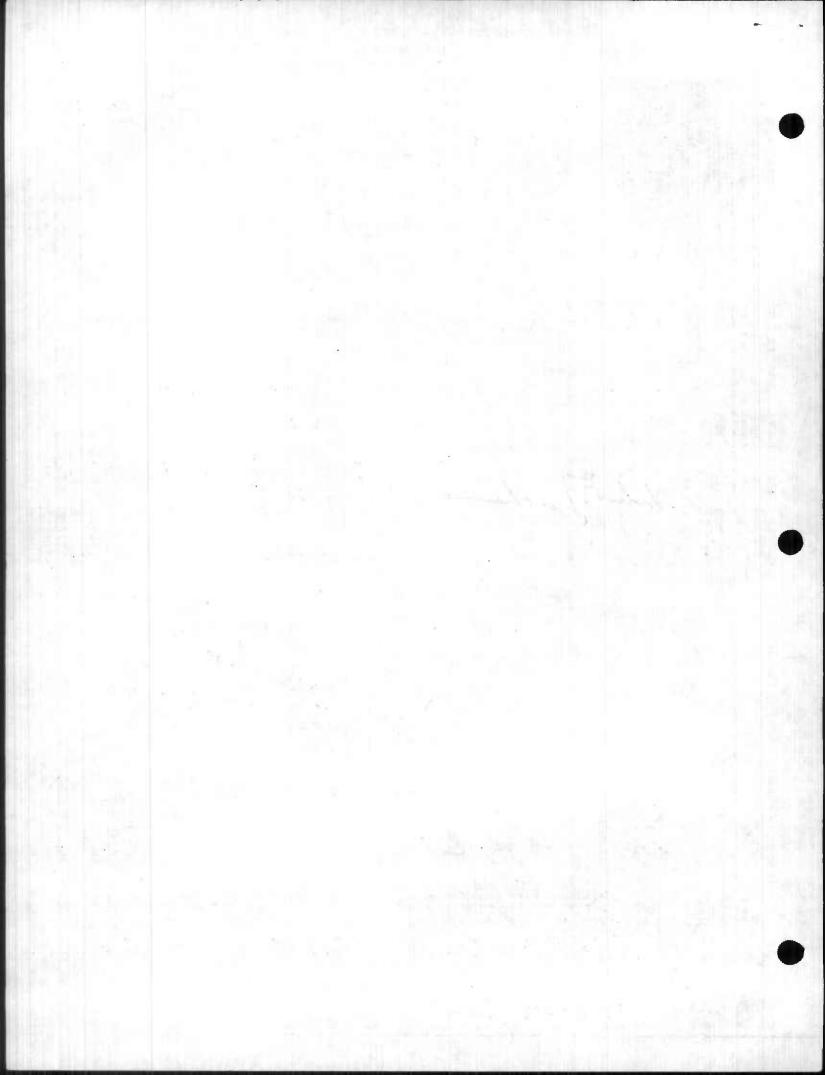
Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier dical (Check only one) 29b. Signature 29c. Licensa number 29d. Data signed (Month, Day, Year) npleted ceusa of death (Itam 23a) (Type, Print) mid 11aRd

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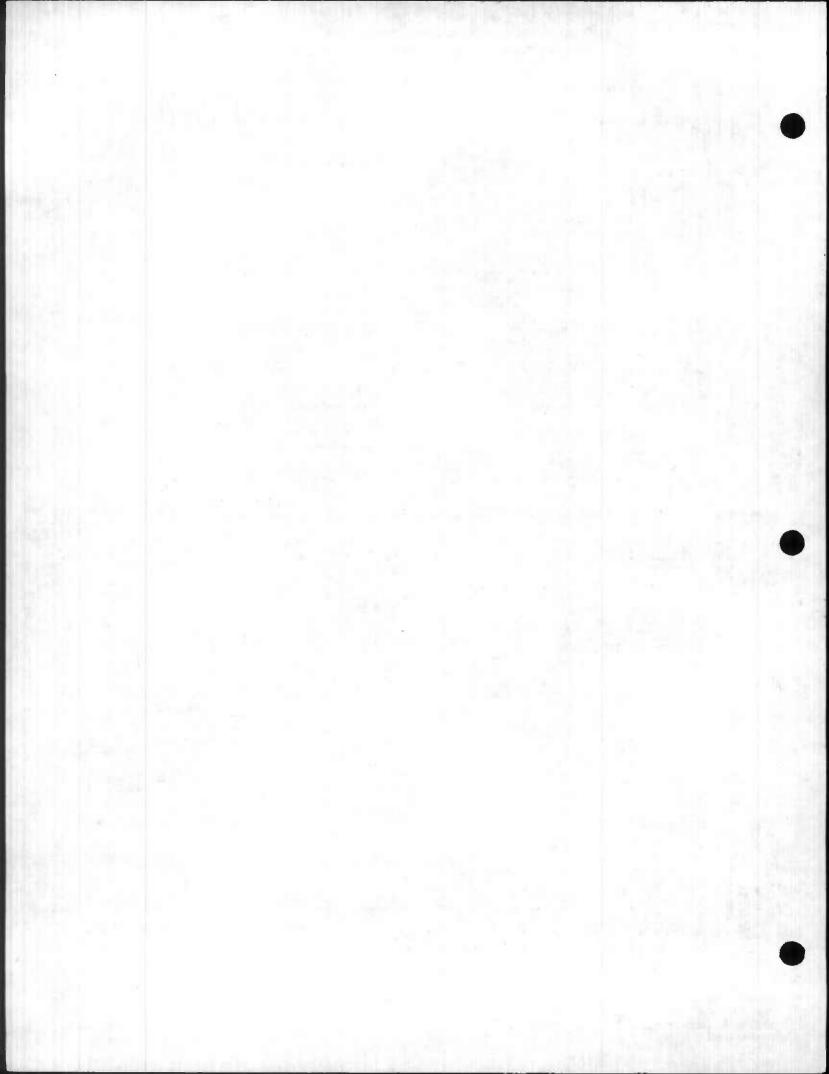
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32. Regisfrar's Signatura



				Certificate of		Re	g. No.	42805				
Physician	1. Decedent's Name (First, Midd	lle, Last)				2. Date of Deat Month	Dey	3. Time of Death				
/Medical Examiner	Roy Frank Go		4b. City, Town, or L	Decembe	00 10:50 PM							
Examiner	10805 Clermo				Commonts E	) a sala						
	5. Social Security Number	-	age (In yrs. lest birt		Garrett P		Montgo					
Funeral Director	100-14-5944	1√2M 2□ F		rs. Months Days	Hours Min.	8. Dete of Birth (Month, Dey, Dec. 30	, 1923	9. Birthplace (State or Foreign Country) New York				
with the Meryland a or 28a-1 show the notified at	Usuel Residence of Decedent  10a. State  10b. Count	у	10c. City, Town	or Location				10d. Inside City Limits				
the Meryla 28a-1 sho notified at	Maryland Mont	gomery	Garre	tt Park				1 Yes 2 □ No				
or 28a-f a	10a. Street and Number			10f. Zip Code		16	Og. Citizen of WI	hat Country?				
th with	10805 Clermon	at Ave		2089	6		United	States				
deeth deeth	11. Marital Status	12. Wes Deceden	t Ever in U,S.	13. Was Decedent of I				- American Indien,				
urs after eli, or its	1 Never Married 3€3 Ma 3 Widowed 4 Divorce	If Yes Give	1No 1942-	If Yes, specify Cub		o Rican, etc.)	Specify:	, White, etc. White				
72 hours	15. Decede	nt's Education est grade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	petion during most of wor	kina	16b. Kind of Bus	iness/Industry				
21215-0 ed within 72 ho ygiene. The Madraul it, the Madraul Completed	Elementary/Secondary (0-12)	College (1-4or	r 5+)	life. DO NOT use retire  Executive	od)		Federal	Government				
d 2 Hygid there	17. Father's Name (First, Middle			DACCULIVE	18 Mother's Nan	ne (First, Middle, A						
aryjand 2. should be filed v and Mental Hygie o marked other t umatic event, in	Phillip Goot				Anna Ba							
Maryia d 2 should th end Men 7 le marke treumatic	19a. Informant's Name/Relation	9	19h	Mailing Address (Street			City or Town S	State Zin Code)				
Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma M	Dr. Joseph Good			209 Tyburn								
ges 1 and tof Health if Rem 27 or other tr	20a. Method of Disposition	Lemberg/ 3011		Disposition (Name of	Terrace,			City or Town, State				
Baitimore, Ma semil. Peges 1 and 2 s separament of Health en mportant: if New 27 is on my injury or other treus Mice.	1 ☐ Burial 2 ☐ Cremation		e cemeter	y, cremetory or other ple								
t. Peg tment tant: h	4 □ Donation 5 □ Other (		Mt. H	ebron Cemet	ery  l	2/24/00	Queens					
Baltimoperation Peg Department Important: Peg enty Injury of page.	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Danzansky-Goldberg M 1170 Rockville Pike Rockville, MD.											
	23a. Part1. Enter the disease, or shock, or heart failure. Lis	or complications that cause	ed the death. Do r	1				Approximate				
Physician /Medical	tmmediate Ceuse (Final							Onset and Death				
Examiner	disease or condition resulting in death)  Acute Myocardial Infarction  2 Weeks  Due to (or as e consequence of):											
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58760, cete be executed physicien end s the burial-transit edical Examiner	Sequentially list conditions.	b										
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cord requir should				Teak.		24e. Was en	n autopsy ned?	24b. Were eutopsy findings eveilable prior to completion of cause of death?				
C 0 48 E						1 □ Ye	s 2k No	1 ☐ Yes 2 ☐ No				
Vitai I	25. Was case referred to medical	al			26. Piece of Dee	oth (Check only on	e)					
hysicianis certification of Vincential direction of Vi	examiner?	Hospital: 1 Inpal	tient 2 ER/Out	toatient 3 DOA Ot	hor	ome 5 🖾 Reside		r (Specify)				
ng Pl fter ti nere nere	27. Manner of Death 1 ☑Natural 5 ☐ Pendi	28a. Dete of In	jury 28b. T	ime of 28c. Injury Wo		28d. Describe how Injury occurred		11 77				
Division of To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could	nined 286, Place of II						or or Rurel Route Number,				
ne Hospiu n 24 hours he Funera pletely fille edical (	29a. Certifier (Check only one)  1   Certifyi 2   Medical	ng Physician: To the bes Examiner: On the basis and menner s	of examinetion and	death occurred at the ti	me, date and place opinion, death occu	, and due to the co rred at the time, do	euse(s) and man ete end place, e	nner as stated. nd due to the ceuse(s)				
Within within comp	29b. Signeture and title of contille	of Call	D. 111	29c. Licen	se number	2	(Month, Day, Year)					
10	north	- Justa	Carl Land	D27:	242	1	20, 2000					
	30. Name and address of person											
_	Joseph E. Go 31. Date filed (Month, Dey, Year			Tyburn Teri	race. Bet	hesda, M	D. 20814	<b>+</b>				
State Registrar	DEC 2 6		trar's Signature	house								

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dala of Death 3. Time of Death Day Month Year Charles Thomas Gillespie December 21, 2000 10:40 pm 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva streat and number) Rockville Montgomery Hospice- Casey House Montgomery If Undar 1 Yaar 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) 5. Social Security Number Birthplaca (Stata or Foreign Country) Months Hours Min. Days **™** 2□ F Yrs. 78 Mar 12, 1922 021-12-8564 Massachusetts Usual Rasidenca of Decedant 10a. Siala 10c. City. Town or Location 10b. County 10d. insida City Limits 1 ☐ Yas 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20906 2900 N. Leisure World Blvd., #102 USA 12. Was Decedant Ever in U.S. Armed Forcas? \[ \times \] Yas 2 \( \times \) No 1942If Yes, Give Yaer or Datas: 1945 Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 X Married 1 Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Federal Bureau of Elementery/Secondery (0-12) Collega (1-4or 5+) Investigation Special Agent 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Thomas Leo Gillespie Gertrude Rourke 19b. Meiling Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2900 N. Leisure World Blvd., #102, Silver Spring, MD Roberta P. Gillespie/ Wife 20b. Place of Disposition (Nema of camatary, crematory or other piece) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Dala 1 X Burial 2 Cremation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 12/28/00 Silver Spring, MD Gate of Heaven Cemetery 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 21. Signatura of Funaral Sarvica Licensae 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enlar ha disaasa, or complications that caused the death. Do not anlar the mode of dying, such as cardiac or respiratory arrest, shock, or ha art failure. List only one ceuse on each line. Approximata Interval Batween Onsat and Death Immediate Cause (Final disaasa or condition rasulting in daath) . Metastatic Prostate Cancer 18 months Dua to (or as a consequence of): Sequentially list conditions, if any, laading to Immadiata causa. Enter Underlying Causa (Disaase or Injury Dua to (or as a consequence of) that initiated evants rasulting in death) Last Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No

**Physician** /Medical Examiner

Examine

Physician/Medical

by

Completed

Be

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Certification:

edicai

3 ☐ Suicide

29a. Cartifiar

4 ☐ Homicida

(Check only

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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"natural", or Name 23s or

permit. Pages 1 and 2 should be filed within 72 hours after death a Department of health and Mental Hygiena. Important: if them 27 is marked other than "natural", or flame 23a any injury or other traumatic event, the last

Directo

Funeral

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Box 68760. Records, Division of Vitai Physician: funeral After ector: /

Hospital or Attending 24 hours after death. 6 5 To the Hospital o within 24 hours af To the Funeral DI completely filled is 12+1

25. Was casa refarred to medical Hospital: 1 ☐ Yes 2 ☐ XNo 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of injury 28c. Injury at Work? 1X Neturel 2 Accident

5 Pending investigation 6 Could not be detarmined 28a. Place of Injury - At homa, farm, straal, fectory, offica building, atc. (Specify)

26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 MOthar (Specify) Hospice 28d. Describe how injury occurred 1 Yas 2 No

28f. Location (Street end Number or Rural Routa Number, City or Town, Stata)

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1 Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end mennar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and file of certifie 29c. License number 29d. Data signed (Month, Day, Year)

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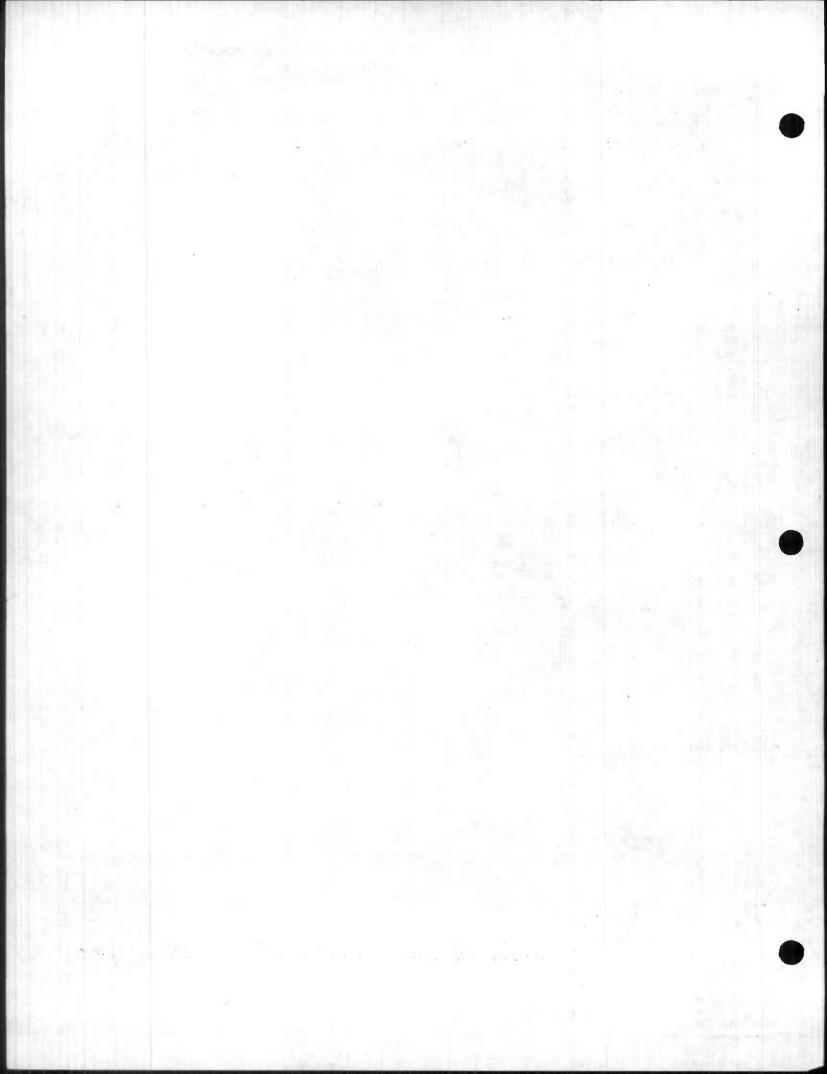
30. Nama and address of person who completed causa of daath (Itam 23a) (Type, Print)

Cheryl Aylesworth, MD 6800 Georgia Ave., Washington, DC

State Registra

31. Data filed (Month, Day, Year)
DEC 2 6

32. Registrar's Signatura Preva



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Willis S. Georgia, Jr. December 26, 2000 3:52 PM /Medical 4a Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7031 Wilson Lane Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Dete of Birth (Month, Day, Year)
May 17, 1914 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□F 194-09-0996 86 Pennsylvania Director Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a Stale 10b County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Exeminar main be notified at 1 ☐ Yes 2 No Maryland | Montgomery Bethesda Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 7031 Wilson Lane 20817 United States Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Marital Status Bleck, White, etc. 72 hours after 1 ☐ Yes 2 ☒ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: p White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) flied within 7 Hygiena. other than "n Elementery/Secondary (0-12) College (1-4or 5+) Communications Specialist permit. Pages 1 and 2 should be file Department of heelth and Mentel Hy Important: If item 27 is marked othe any Injury or other traumatic event, phose. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Willis S. Georgia, Sr. Vera Scott 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gladys S. Georgia/Wife 7031 Wilson Lane, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Dec. 28, 20c. Location - City or Town, State 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removal from State Montgomery Crematorium, Inc. 2000 Bethesda, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Chase, Inc. Bethesda, Maryland 20814-3501 21. Signeture of Funeral Service Ligensee M00198 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsel and Death **Physician** /Medical tmmediate Cause (Final disease or condition resulting in deeth) Carcinoma of the Prostate 5 years Examiner Due to (or es e consequence of): Examine attending physician and for use as the burial-transit The lew requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by to 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? should I 24a. Was an autopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital Physician: 25. Was case referred to medical examiner? director Be 26. Place of Deeth (Check only one) Hospital: 1 Inpalient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 10 1 ☐ Yes 2 🔀 No After this c 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 27. Menner of Death 28c. Injury at 28d. Describe how injury occurred Certification: Division or Attending 1 Neturat 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) after 4 T Homicide Hospital Pilled 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner. Stated. edical npietely (Check only within 2. To the F 5 29b. Signature and fitta of continu 29c. License number 29d. Date signed (Month, Day, Year) D23783 December 27, 2000 ond

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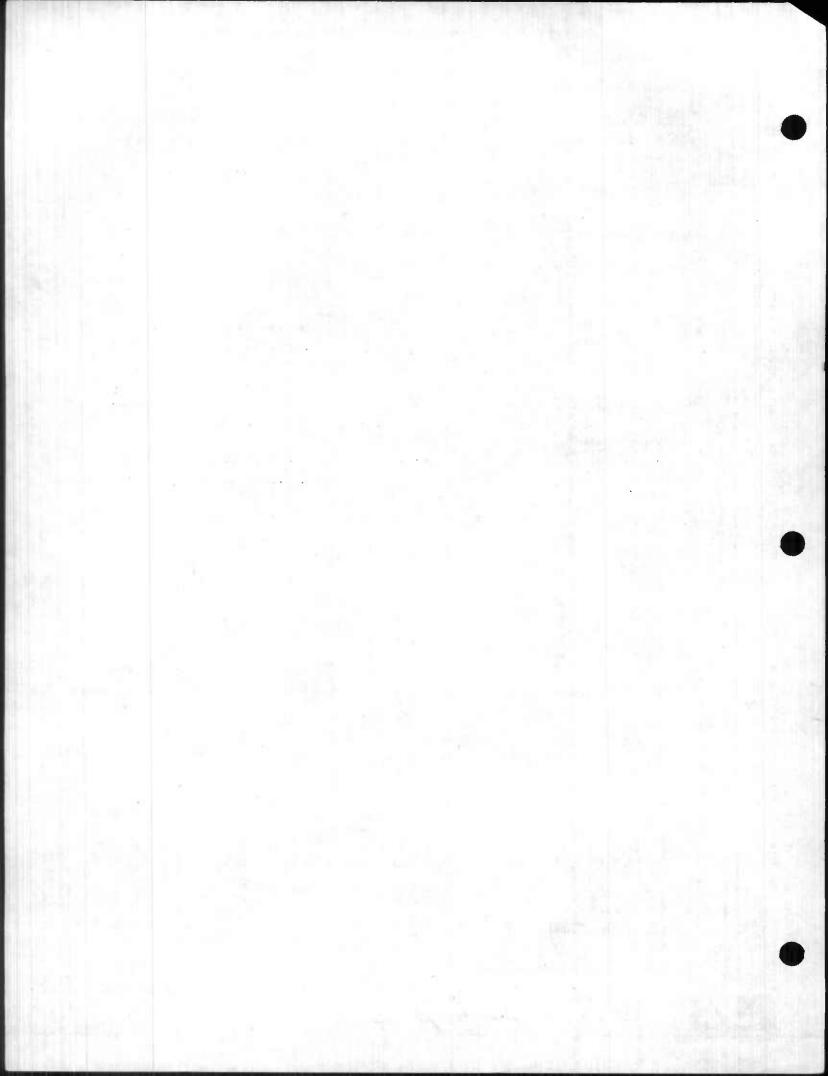
30. Name and address of person introcompleted cause of death (Item 23a) (Type, Print) Daniel J. Esposito, M.D. 5530 Wisconsin Avenue #1400, Chevy Chase, Maryland 20815

State Registrar

31. Date filed (Month, Dey, Year) DEC 2 9 2000



oaks



State of Maryland / Department of Health and Mental Hygiene-

Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** 25, 2000 DEC. 2:20 PM MARGARET E. GAITHER /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner MONTGOMERY Olney Montgomery General Hospital If Undar 1 Yaar if Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) Oct. 14, 1932 9. Birthpiaca (Stata or Foraign Country)
Maryland 7. Aga (In yrs. last birthday) 5. Social Sacurity Number 6. Sax **Funeral** Min. 1 M 2 SXF Months Days Hours 68 Yrs. 214-32-9065 **Director** Usual Rasidance of Decedant 10c. City, Town or Location 10a Stata 10b. County 10d. Insida City Limits show 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinat must be notified at 1 XYas 2 No Sandy Spring Directo Montgomery MD 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? U.S.A. 18834 Chandlee Mill Road 20860 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 ☐ Yas 2X No If Yes, Give Yaar or Dates: 1 Navar Marriad 2 Married 1 Yas 2√ No Spacity: Specify: Black p 3 ₩ Widowad 4 Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiena. Elemantary/Secondary (0-12) Collega (1-4or 5+) 9th Cafeteria Helper Montg. Co. Schools 18. Mothar's Nama (First, Middla, Maidan Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked otherny injury or other traumatic event 17. Fathar's Nama (First, Middla, Last) Be George Powell Carrie Addison 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 0 8 6 0 19a. Informant's Name/Ralationship (Type, Print) Terry Lee (Daughter) 18834 Chandlee Mill Rd., Sandy Spring, MD 20b. Place of Disposition (Name of camatary, cramatory or other plece) Date 20c. Location - City or Town, Stata 20a. Mathod of Disposition Durial 2 ☐ Cramation 3 ☐ Ramoval from Stata Ash Memorial Cem 12/28/00 4 Donation 5 Othar (Specify) Sandy Spring, MD 22. Nama and Addrass of Fecility
SNOWDEN FUNERAL HOME, P.A. 21 Signature of Funeral Service Agense 246 N. Wash. St., Rockville, MD 20850 23a. Parti. Enter use disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or hand failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Daath **Physician** Immediate Cause (Finet disease or condition resulting in death) /Medical Acute Respiratory Failure 4 days Examiner Due to (or es e consequence of): Examiner Chronic Obstrucgive Pulmonary Disease 2 years physiclen end the buriel-transit Sequantially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a consequence of): Ischemic Cardiomyopathy 3 years Physician/Medical that initiated evants resulting in death) Last Dua to (or as a consaquanca of): SE esn for ed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1X Yes 2 No 3 Probably 4 Unknown signed t Coronary Artherosclerosis þ 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? Completed Type II Diabetes Mellitus completion of ceuse of death? page 2 s Jas 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate Attending Physician: director. Be 25. Was cesa refarred to medicel axaminar? 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) P 1 Yas 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Dete of Injury (Month, Day Year) Certification: 27. Mennar of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Naturel 5 Pending s efter dea. 1 Yas 2 No invastigation 2 Accidant 6 Could not be 3 Sulcida Location (Street and Number or Rural Routa Numbar, City or Town, Stata) 28e. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicida Hospitai 24 hours Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data end place, and dua to the ceusa(s) and mannar as stated.

| Medical Examiner: On the basis of axeminetion end/or invastigetion, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and mannar stated. 29a. Certifian edicai taly (Check only one) To the Vithin 2 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar D35045 Dec. 25, 2000 10 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) M.D. 3416 Olandwood Ct., #204, Olney, MD 20832 Philip G. Henjum, 31. Data filed (Month, Day, Year) 32. Registrar's Signatura Registrar

DEC 27 2000

**DHMH 16 Rev 6/95** 

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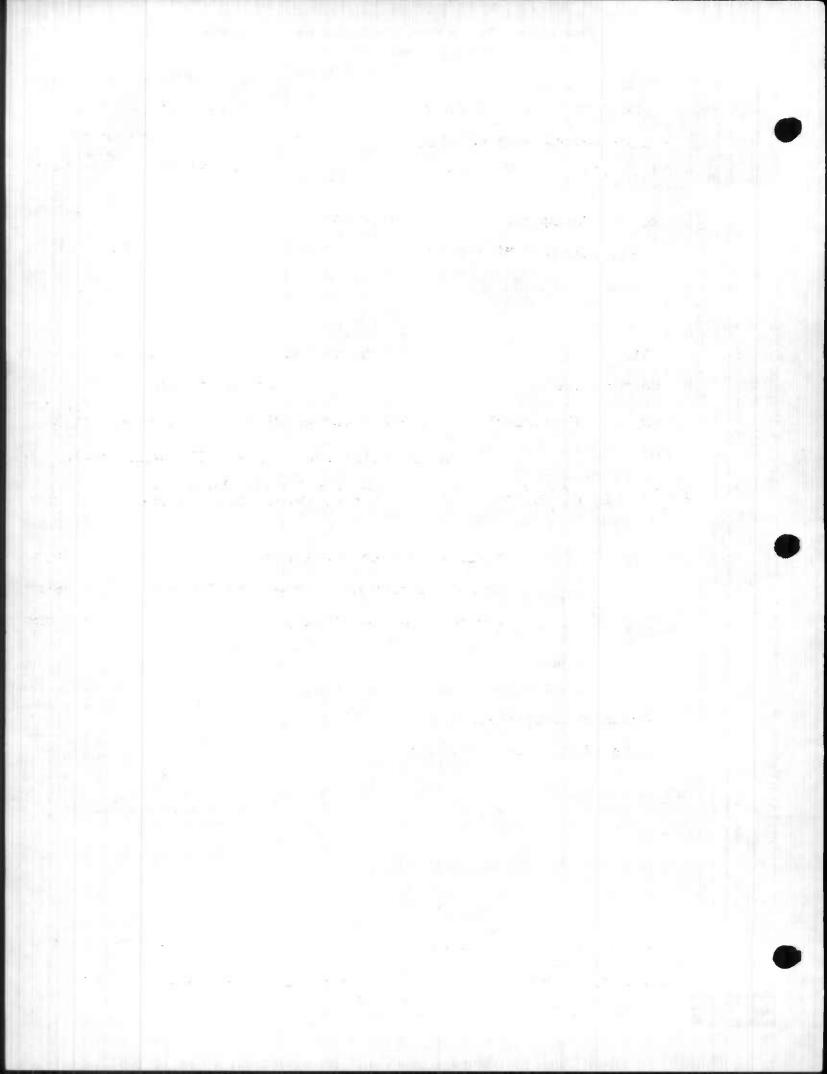
certificate be executed

Box 68760,

P.O.

Division of Vital Records.

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Jesse Horse /Medical December 20 2000 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Wicomico Deer's Head Center Salisbury
Under 24 Hrs. 8.
Hours Min. 5. Sociel Security Number If Under 1 Year 6 Sev 7. Age (In yrs. last birthdey) Date of Birth (Month, Dey, Yeer) **Funeral**  Birthplece (State or Foreign Country) Days 1 M 2 F Director 218-24-4196 3-23-08 Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director WICOMICO 1 Yes 2 No MD. SALISBURY 10e. Street end Number 10g. Citizen of Whet Country? 21801 1703 DQUARE Completed by Funeral USA 12. Was Decadent Ever in U,S. Armed Forces? 14. Reca - American Indien, Bleck, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 No 3 Widowed 4 □ Divorcad Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CARPENTER DON 17. Father's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Melden Sumeme) Be WILLIAM G. HORSE MARY GALE HORSEY 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ELAINE PATTERSON-GUARDIAN 20b. Place of Disposition (Name of cametery, cremetory of other place)

20b. Place of Disposition (Name of cametery, cremetory of other place)

20c. Location - City or Town, State 20a. Method of Disposition Cremetion 3 Removel from State
Constitution SQther (Specify) 12/27/2000 HARSON'S -EMETARY DALISBURY 21. Signature of Funeral Service Licenses 22. Name end Address of Facility BENUIS SMITH 917-W. ISABELLA ST. SALISBURY, MD. 21801 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physiclan** /Medical Immediete Ceuse (Final disease or condition resulting in deeth) Due to (or es e consequence of): and spiones 3 week Examiner Examiner i or Attending Physician: The law requires that the death certificate be axecuted after death.

Director: After this certificate has been signed by the ettending physician and Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of) Box 68760, Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? this certificata has 20 No 1 Yes 1 Tyes 2 No 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 20 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of fnjury 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 2 Accident 5 Pending investigation To the Hospital or Attendir within 24 hours aftar death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) end manner stated. Medicai 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

PO BOX 2018,

32. Registrer's Signature

Salisbury, MD 21802-2018

State Registrar In a Hwang.
31. Dete filed (Month, Day, Yeer)

DEC 2 6 2000

M.D

Mo Wicomice Surreiney WILLIAM G HORSEY ELMINE POPTERSON-GRADING 1973 CAMPER SOUTHLE SALES SALES AND 20161 HARRING CENTERNY MENTANG SHALL SHARE OF THE

State of Maryland / Department of Health and Mental Hygiene

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	Grace Frances Horne							Month Decemi	per 25	Yeer . 2000	11:05pm		
Medical xaminer	4a Facility Neme (# no	ot institution, give	e street end number)			- 4	lb. City, Town, or	Location of Death	4c. County				
	Greater	Baltin	nore Med.	ical Ce	enter		Towson	2	Bal	timore			
al	5. Social Security Num			e (In yrs. lest bir	thdey) If Unde Months	1 Year Deys	If Under 24 Hrs Hours Min	8. Date of Birth	Year)	9. Birthplece (5	State or Foreign		
п	215-10-51	1.7	□M 2√2 F	92	Yrs.			Apr 1	7 1908				
	Usuel Residence of De	ocedent Ob. County		10c. City, Tow	n or Location					10d Ins	ide City Limits		
6	m D		imore	THE LINES CO.							Yes 2 No		
Director	10s. Street and Numbe		Imure	Tow	5 U II 10f. Zij	Code		T.	log. Citizen of V		Х		
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Funeral	20 Dunva	le kua	12. Wes Decedent	Ever in I.I.S.	12 Was Door	212		Engeily Vac or No.	USA	e - American Ind	100		
5	11. Marital Stetus	217 Married	Armed Forces?	Section .	If Yes, spe	cify Cuba	in, Mexicen, Puer	Specify Yes or No- to Rican, etc.)		ck, White, etc.	,		
by	₩idowed 4 E		1 Yes XIII If Yes, Give Year or Detes:	**	1 ☐ Yes	2 🔯 No	Specify:		Specify	a Whit	Ę		
		. Decedent's Ed		160.	Decedent's Usu	el Occup	ation		16b. Kind of Bu	usiness/Industry			
ple	(Specify (	only highest gra	de completed)		(Give kind of wo	ork done d se retired	during most of wo	orking					
Completed	Elementery/Seconde	, y (U-12)	College (1-4or !	/*/	Homema	aker			Own H	ome			
Be C	17. Father's Name (First	st, Middle, Last)						me (First, Middle,			1-		
To B	Joseph Mi	oylan					Johan	na O'Ke	efe				
	19e. Informent's Neme	/Reletionship (7	Type, Print)	196	. Meiling Addres	s (Street	end Number or R	ural Route Numbe	r. City or Town,	Stete, Zip Code)			
	John Wal:	lace/n	ephew	2	526 01	a wa	shingt	an Rd W	estmin	ster.	MD21157		
	20e. Method of Disposi			20b. Piece o	Disposition (Ne	me of	1	2/249/20	300 Location -	City or Town, St	ete		
		20e. Method of Disposition  1 Burial 2 AlCremetion 3 Removed from State  4 Donetion 5 Other (Specify)  20b. Plece of Disposition (Neme of cemetery, cremetory or other plece)  Carroll Cremation, Inc Hampstead, MD											
n	21. Signature of Funer	el Service Licen	1000 A		22. Neme e	nd Addre	ss of Fecility_	Home an	1 41				
S	A.C.	u cnapel minster, MD 21157											
	23a Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, or heart failure. List only one cause on each line.										oximete		
1	pack, or heert ta	ulure. List only	one ceuse on each li	ne.							el Between t and Death		
al al	Immediate Cause (Fin	al	M.,	· · · · · · · · ·	il t	a An	rtia			1/1			
	disease or condition resulting in death)		a. 119	Due to for es e	consequence of)		CILON			16 /	// 3 ,		
ě			Pres	1 monja	consequence or,					110	Pun		
Examiner	Sequentially list condit	ions.	b	Due to (or as e	consequence of)					100	ary		
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D D	1000							24a. Wes	an eutopsy med?	24b. Were eu eveileble	prior to		
ted by										of death?	on of ceuse		
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3e Completed by Physician/M	25. Wes case referred	to medicel					26. Place of De	eth (Check only o	ne)				
To Be Completed by	25. Wes case referred examiner?		Hospitel: 1 Inpatie	ent 2 ER/Ou	itpetlent 3□ D	Oth Oth	or:	eth (Check only o		er (Specify)			
on: To Be Completed by	examiner? 1 Yes 2 No 27. Manner of Death		Hospitel: 1 Inpatie	ry 28b.	Firme of	OA Oth	er: 4 Nursing		ence 8 🗆 Oth				
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To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Neturel  2 Accident  3 Suicide  4 Homicide  29e. Certifier (Check only one)  29b. Signature and title  30. Neme end address	Dending investigation investig	28e. Plece of Injumental Plant State	y Year) 28b. y Yea	orm, street, tactor door investigation  (Type, Print)	28c. Injur Word 1 D y, office et the tim, in my oc. Licens	er: 4 Nursing y at k? Yes 2 No ne, date end place pinion, deeth occ e number 3 172	Home 5 Resid 28d. Describe h 28f. Location (5 City or Tow e, end due to the curred et the time, (	ence 8 Oth ow injury occur itreet end Numb m, Stete)  cause(s) and me lete and piece,	per or Rural Rout enner es stated. end due to the c	ause(s)		

DHMH 16 Rev 6/95

**ORIGINAL** 

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The law requires that the death certificate be axecuted Box 68760 Records, P.O. ueeq Vital Physician: Division of or Attending death.

577-07-7656

EUGENE HIGGINS

Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** EUGENE STALEY HIGGINS 18:33p.m. 12-27-2000 /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Memorial Hospital & Medical Center **Allegany** Cumberland If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
SEPT 8 1900 If Under 1 Year Birthplace (State or Foreign Country)
 MARYLAND 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Deys Yrs. 577-07-7656 100 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mantai Hygiene. important: If fitam 27 is marked other than "natural", or itema 23a or 28a-f ahov any Injury or other traumatic avant, the Madeal Example, must be notified at once. 1 Yes 2 No Directo MARYLAND ALLEGANY OLDTOWN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 18101 OLIVE BELTZ ROAD S.E. 21555 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Merried Specify: WHITE 1 Yes 2 No Specify: p 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) WASHINGTON GAS COMPANY ACCOUNTANT 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES PRATHER HIGGINS MARY WASHINGTON WARFIELD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANETTE McBURNEY GRANDAUGHTER 40229 th 95 WOODSFIELD OHIO 43793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ICremetion 3 ☐ Removal from State CUMBERLAND CREMATORY DEC 28 2000 CUMBERLAND MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate Intervel Between Onset and Death **Physician** tmmediate Ceuse (Finet disease or condition resulting in death) /Medical Right Middle Lobe Pneumonia day Examiner Due to (or as a consequence of): Physician/Medical Examiner signed by the attending physician end detached for use as the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease, Dehydration by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? Completed **Director:** After this certificate has I 1 Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Injury at Work? 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C edical 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Damo lus Junen D0014865 December 28,2000 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barrera, Robustiano J., M.D. Memorial Medical Bldg., Cumberland, Maryland 21502

State Registrar

31. Dete filed (Month, Day, Year)

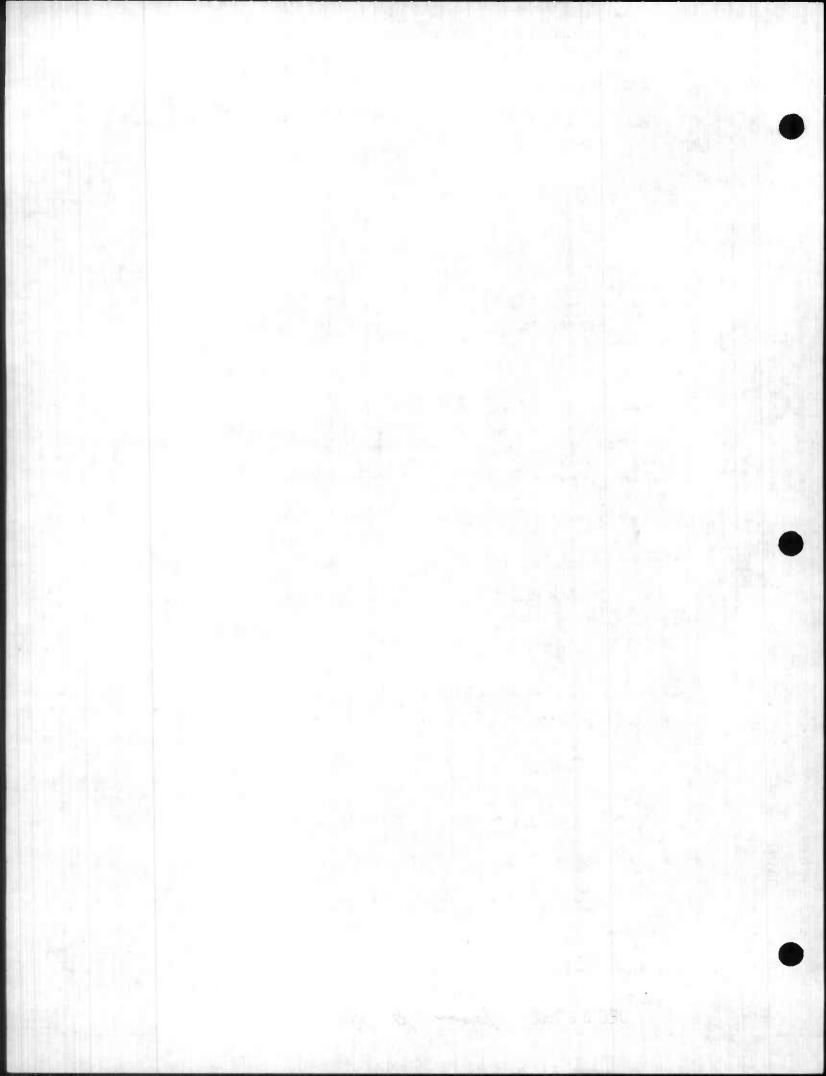
DEC 29 2000

**DHMH 16 Rev 6/95** 

**ORIGINAL** 

32. Registrer's Signeture

renewa



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death DECEMBER 26,2000 SR. WILLIAM BARTON HUNGERFORD 2:20 AM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6001 Muncaster Mill Road, CASEY HOUSE ROCKVILLE MONTGOMERY If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) FEB.22, 1934 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) MARYLAND 1 M 2 F Months Days Hours Min 217 28 8325 66 Usual Rasidance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits MONTGOMERY MD. DERWOOD 1 Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 17401 BOWIE MILL ROAD 20855 UNITED STATES 12. Was Decedant Ever in U.S. Armed Forces? 1 Decedant Ever in U.S. 1954 – TYas, Giva Year or Datas: 1964 Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married 1 Yas 2 No Specify: WHITE Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) 4 PRESIDENT / DEVELOPER REAL ESTATE 18. Mothar's Neme (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middle, Last) ALLAN G. HUNGERFORD MARION ٧. BLUNT 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) DIXIANNA HUNGERFORD, WIFE 17401 BOWIE MILL ROAD, DERWOOD, MD. 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1X Burial 2 Cramation 3 Ramoval from State CHRIST EPISCOPAL CEMETERY 1/3/01 WAYSIDE, MD. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licenses 22 MURTEL Address of ARBER FUNERAL HOME uer P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the diseasa, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximata Intervel Between Onsat and Death Immediata Causa (Final disaasa or condition resulting in deeth) LUNG CANCER 18 MONTHS Dua to (or as a consequence of): Dua to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown 24b. Wera autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed?

**Physician** /Medical **Examiner** 

attending physicien and for use as the burial-transit

rthis certificate has been signed by the irral director, paga 2 should be detached

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completally filled in by the funaral director;

The lew requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760.

Examine

Physician/Medical

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Completed

Be

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Certification:

edical

permit. Peges
Department of
Important: If the
any injury or o

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

**Funeral** 

Director

e filed within 72 hours after death with the Maryland at Hygiene.

1 Hygiene.

1 Hygiene.

23 or 28e-f show vert, the Made Earth or mother show vert, the Made Earth or mother at the notified at

Peges 1 and 2 should be finent of Health and Mental First: If Item 27 is marked of

Baltimore, Maryland 21215-0036

Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Ceusa (Diseasa or Injury that initiated evants rasulting in death) Last

1 Natural

2 Accident

3 ☐ Suicide

4 Homicida

Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I.

1 Yas 2 No 1 Yas 2 No

25. Was case refarred to medical 26. Pleca of Death (Check only one) examinar? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yas 2X No 27. Mannar of Death

28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred Injury at Work? 5 Pending invastigation 1 ☐ Yes 2 ☐ No 6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

12 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the best of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only one)

29b. Signature and title of cedibe 29c. Licanse number 29d. Date signed (Month, Day, Year) MO D 35635 **DECEMBER 26,2000** 

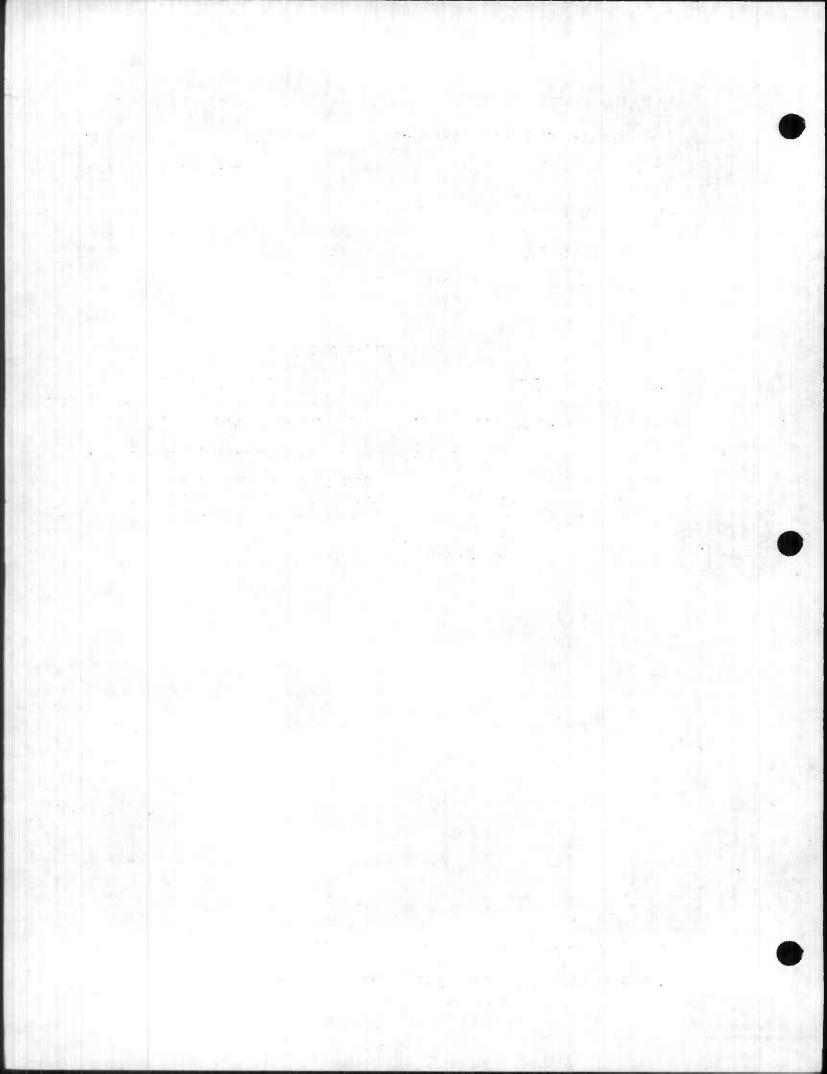
30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

JOSEPH KAPLAN, M.D., 18111 PRINCE PHILIP DRIVE, OLNEY, MD. 20832

State Registrar

31. Data filed (Month, Day, Year) DEC 27 2000 32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 1 4 28 15

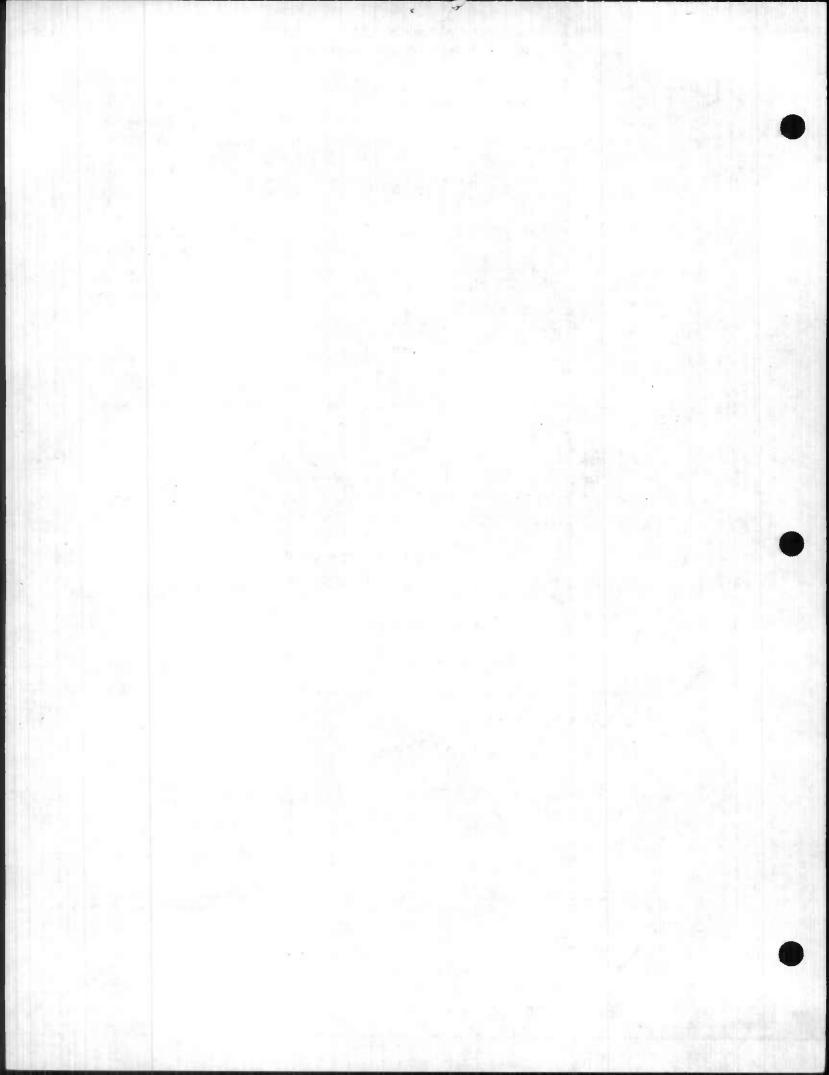
					Cert	ificate o	f Death	Re	eg. No.	7 6	.01	J
<b>.</b>	. 1	1. Decedent's Neme (First, Middle, Las	ot)					2. Dete of Deet	h	V.	3. Time of	f Deeth
Physic /Med		Mary Anita Hughes						Decembe	Dey r 27, 2	Year 2000	9:15	am
Exami		4e. Fecility Neme (If not institution, give					4b. City, Town, o	r Location of Death	4c. County			
		3242 Gleneagles Dr	. Apt. 2	F		200	Silver S	pring	Montgo	omery		
Funeral		Social Security Number     6. Security Number	DA4 OXX	je (In yrs. lesi		If Under 1 Yes Months Day	ir If Under 24 Hr		Year)		ce (Stete c	or Foreign
Director		578-03-4723	B4		Yrs.	1 18		January	12, 19	916 D	C	
and **		Usuel Residence of Decedent  10a. State 10b, County		10c. City. T	own or Loca	ation				100	d. Insida Cl	thy I Imite
Aaryl sho	5									100		2 No
the N	Director	Maryland Montgome  10e. Street end Number	гу	Silve	er Spr	10f. Zip Code		1 41	Og. Citizen of \	After Court		
viii v										vnet Country	y r	
permitt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Event real continued and once.	Funeral	3242 Gleneagles I	12. Was Decedent		13 W	20906	Hispanic Origin?	Specify Yes or No-	SA 14 Bac	a · Americar	n Indian	
the d	F	1 Never Merried 2 Married	Armed Forces?		If Y	Yes, specify Cu	iben, Mexican, Pue	erto Rican, etc.)		ck, White, et		
irs at	by	3 Widowed 4 Divorced	1 Yes 2XX If Yes, Give Year or Dates:		10	Yes MY	o Specify:		Specify	<i>(</i> :		
d within 72 hours af glena. If then "natural", or the medical Exam.		15. Decedant's Ed	ucetion	1	6a. Decede	nt's Usuel Occ	upation		16b. Kind of B		strv	
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s and h		19a. Informent's Name/Reletionship (7	ype, Print)		19b. Melling	Address (Stre	et end Number or I	Rural Routa Number,	City or Town,	Stete, Zip C	ode) 20	)906
and alth		Brereton Hughes/H	lusband		3242	Gleneag	gles Dr.	Apt. 2F,	Silver	Sprin	g, MI	)
Toth Toth		20a. Method of Disposition  1 Burial 2 Cremetion 3	D	20b. Plac	e of Disposit	tion (Neme of story or other p	lece)	Date	20c. Location -	City or Town	n, Stete	
Description of the property of the property of the permit and 2 should be file bearing and Mental Hy mportant: if New 27 is marked oth my lajury or other traumatic event 2008.		4 □ Donation 5 □ Other (Specify						12/30/00	Silve	er Spr	ing.	MD
permit. Departrimports any Inju		21. Signeture of Funeral Service Licen-	500		22.1	Name end Add	ress of Fecility			-		
28 5 8		De double	10.11.					s Funeral			100	0000
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The law requires that tha death ate has been signed by the attar page 2 should be detached for the	Physician/	Pert II. Other eignificant conditions co	ntributing to death b	ut not resultin	g in the und	lerlying cause	given In Part I.	23b. Did to	bacco use co	ntribute to t	he cause o	of death?
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yslcian: The la is certificate ha director, page	Be	25. Was cese rafarred to medicel examinar?					26. Place of D	eeth (Check only on	a)		-	
physic this ce	70	1 Yes 2 No	Hospitel: 1   Inpatie	ent 2 ER	/Outpetient	3 DOA	Other: 4 Nursing	Home 5 KReside	nce 6 Oth	er (Specify)		
Attending Physician: or daath. by the funeral director.		27. Manner of Deeth  1 Netural 5 Pending	28a. Date of Inju	ry 28	b. Time of Injury	28c. in	jury et	28d. Dascribe ho	w injury occur	red		
or Attending Physicien: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	atic	2 Accidant Investigation			,,		Yes 2 No					
or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be datermined	28a. Place of Injubuilding, etc	ury - At homa	, ferm, stree	t, factory, offic	8	28f. Location (Sti City or Town		er or Rural F	Route Num	ber,
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Hospital 24 hours Funeral ately filled	edicai	29a. Certifier 1 Certifying Phy	sicien: To the best of	of my knowled	dge, deeth o	occurred et the	tima, data and plac	ce, end due to the ce curred at the time, da	use(s) end ma	innar es stet	ed.	
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To the within To the comple	-	29b. Signeture and title of cartifier				A	nse number	28	d. Date signe	d (Month, De	y, Year)	
10		Jen Hou	m			146	18381		12/2	17/2	1000	2
		30. Name end edd/ess of person who c								,		
			Prince Ph	ilip D	r., 0	lney, N	D 20832					
Sta	ate	31. Dete filed (Month, Dey, Year)		er's Signeture	4	las "						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year December 25, 2000 **Physician** Anna M. Hedderich 6:15 AM /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY # Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 26, 19 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 KF 84 Yrs. 133-07-0244 Director Usual Residence of Decedent 10a. Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flams 23s or 28s-f show the Medical Examiner must be notified at 1 No Yes 2 No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19301 Watkins Mill Road 20879 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 NWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filled within 7 Hyglene. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 10 permit. Pages 1 and 2 should be fine.
Department of Health and Manfall Hyp.
Important If Item 27 is meric.
any injury or other. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 86 John Fitzgerald Margaret Kelly 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene M. Sherwood/Daughter 12805 North Point Lane, Laurel, Maryland 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition December 1 XBurial 2 Cremation 3 Removal from State Long Island National Cemetery 29, 2000 Pinelawn, New York 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licanom 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. M00846 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Pent. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intervat Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) 2day Examiner Due to (or as a consequence of): Physician/Medical Examiner 2 9 9 21 YCSEDSI The law requires that the death certificate be executed signed by the attending physician and dibe detached for use as the burial-trans Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) 24971 Division of Vital Records, P.O. Box 68760, Verwonia Due to (or as a consequence of): वे ववा espirater Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nuknown Def posigion 2 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy parformed? Completed page 2 should atrial fibrillation peed After this certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 DRNo Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred pital or Attending Pi ours after death. heral Director: After I filled in by the funer Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completaly filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. edical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D 41165 MD December 25 2000 10 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) 19529 Doctori Drive Germanteun ma raphi WD 31. Date filed (Month, Day, Year) DEC 2 7

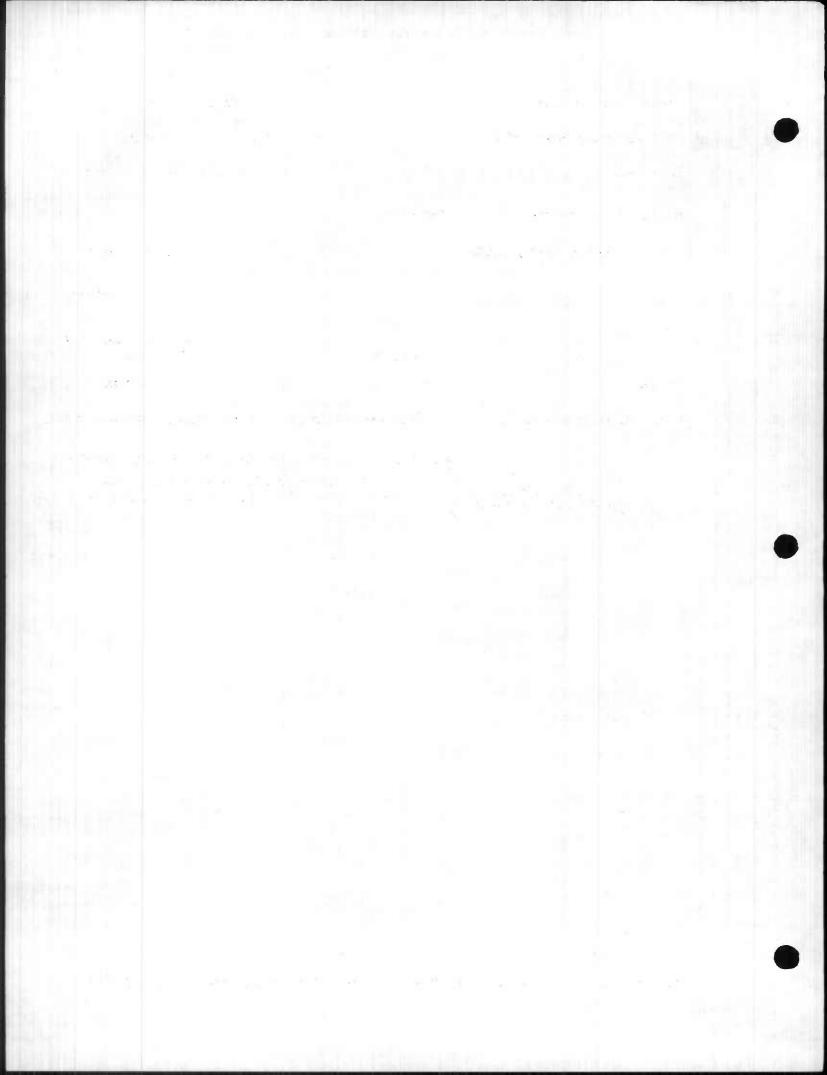
State Registrar 32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Dec. **Physician** Anne W. Herman 1:00P. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6111 Montrose Road, #503 Rockville Montgomery If Under 1 Yaar | If Under 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** Days Min. 10 M 200 Months Hours Yrs. 90 103-09-3011 Feb.11,1910 Virginia **Director** Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Montgomery Rockville Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 6111 Montrose Road, #503 20852 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 Yes 2 XNo If Yes, Give Yaar or Dates: 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: White Specify: by 3 ₩ Widowed 4 Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry City of Richmond Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Teacher Virginia 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth jury or other traumatic even Be Herman Wilkins Mary Gelblum 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Debra H. Berger - Daughter 2929 Greenvale Road Chevy Chase, Maryland 20815 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cramation 3 ☐ Removal from State permit. Page Department of important: If any injury or Lebanon Cemetery 12/26/2000 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Spacify) Donald V. Bordwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 had been so complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrast, heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Ceusa (Final diseese or condition resulting in death) /Medical Struke 7 days Examiner Dua to (or as a consequenca of): Examiner Hyper tension physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequenca of): attending ph for use as t ed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 MUnknown signed I Breat CANCER by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed hypor thypoid s certificate has b 1 Yes 20 No 1 ☐ Yes 2 ☐ No i or Attending Physician: aftar death. Director: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No Other: 4 ☐ Nursing Home 5 KResidenca 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 SNatural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide Hospital 24 hours a Funeral D 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai tely (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. To the To the Complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Darut 5 December 24, 2000 D 39190 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) J. Garrett Reilly, M.D. 11510 Old Georgetown Road Rockville, Maryland 20852

State Registrar 31. Date filed (Month, Dey, Year)
DEC 28 2000

32. Registrar's Stonature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #26,12/28/2000, BMW, Montg. Co. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** C. Daniel 9:35 am Hartman December 22, 2000 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 18604 Muncaster Road Derwood Montgomery ff Under 1 Year | If Under 24 Hrs Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Hours Days 1X M 2□ F Apr 29, 1944 56 Mary1and Director 215-46-6677 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Name 23s or 25s-f show ther must be notified at 1 Yes X No Directo Maryland Baltimore Perry Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 4814 Vicky Road USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or Itam odical Examinar Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed W Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filled within Hygiens. Wher then Elamantary/Secondary (0-12) Collega (1-4or 5+) Roofing Estimator General Contracting 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be Maritai h and Mental Charlotte Udris William E. Hartman 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 Health em 27 William E. Hartman, Jr. (Brother) 18604 Muncaster Road, Derwood, MD 20855 Baltimore, or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1∑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery |12/17/00 Silver Spring, MD 22. Name and Address of Facilit 21. Signature of Funeral Service Licensy Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD20901 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or learn hillure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Metastatie Esophageal Cancer /Medical 6 months Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Due to (or as a consequance of): attending physician I for use as the buria Physician/Medical Due to (or as a consequence of) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yss 2 No 3 Probably 4 Unknown g 24b. Were autopsy findings available prior to completion of cause of death? certificate has been si lirector, page 2 should 24a. Was en eutopsy Completed 1 Yes 2 No 1 Yas 2 No of Vital al or Attending Physicien: The safe death.

I Director: After this certificated in by the funeral director, particular and in by the funeral director, particular and parti 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home - Desidence (X) Other (Specify) residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28c. tnjury at Work? 28b. Tima of 28d. Describe how injury occurred 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Straet and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

To the Hospital of within 24 hours a To the Funeral Completely filled in the Funeral Completely filled in the second seco

29b. Signature and title of certifier

Medical

29c. Licanse number

29d. Data signed (Month, Day, Year)

December 26, 2000 D0050753

30. Name and address of person who completed ceuse of death (Itam 23a) (Type, Print)

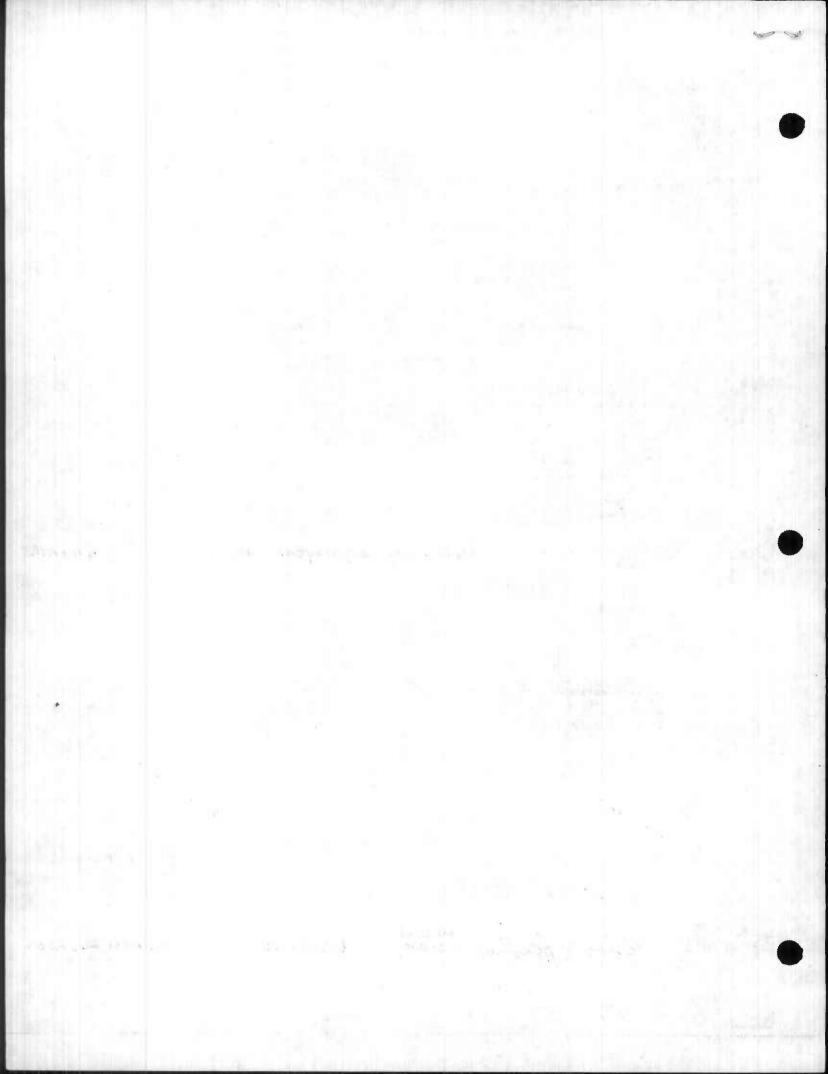
21287 Elizabeth Heath, MD 600 N. Wolfe Street, Baltimore, MD

31. Date filed (Month, Day, Year) DEC 28 2000 Registrar

32. Registrar's Signature

souls!

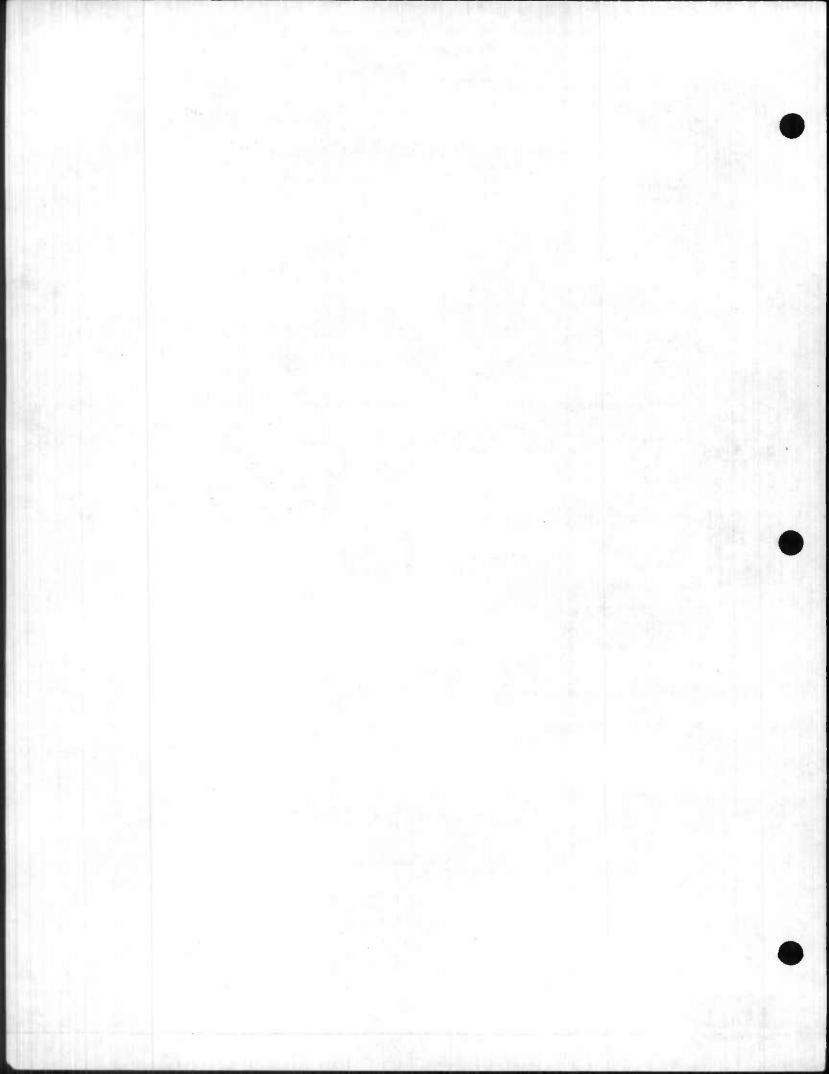
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Margaret A. December 23, 2000 ocation of Death 4c. County of Death 12:20 pm Hamill /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Rehabilitation and Nursing Center Burtonsville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□M 20 F 82 Director 103-12-2202 July 22, 1918 New York Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits i Hygienn other than "natural", or herns 23s or 28s-1 show went, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13020 Gordon Circle 21742 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Bace - American Indian 11. Maritel Status Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: þ 3℃Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Statistician 5+ Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be Montal marked William Smith Kathleen Faglon pure 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 at Department of Health are Important: If them 27 is n # 13020 Gordon Circle, Hagerstown, MD James P. Hamill / Son 21742 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State Jan 5 1 Buriel 2 Cremetion 3 Removal from State 8 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery2001 Arlington, VA 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Chronic Obstructive Lung Disease Examiner Due to (or as a consequence of): Examiner certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Box The lew requires that the death 23b. Did tobacco use contributs to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yss 2 No 3 Probably 4 Unknown py Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 should Completed After this certificate has 1 Yes 2 No 1 Yes 2 No of Vital Physician: eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Division Attending 5 Pending investigation 1 Natural deeth. 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A after 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier -29c. License number mel D37801 December 26, 2000 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Aimee Seidman, 2309 Shorefield Road, Wheaton, MD 20902 MD 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State **DEC 27** oaksi 2000 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death Month Day Vaai **Physician** December 25, 2000 Marie D. Hagner 1515 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel General Hospital Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M SOXF Director 89 Jan. 17, 1911 Pennsylvania 183-16-4080 Usual Residence of Deceden The Maryland 10s State 10b. County 10c. City. Town or Location 10d Insida City Limits 1 ☐ Yas 2 XXNo Directo 28a-f Maryland Anne Arundel Annapolis 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 21403 United States Funeral 84 North Old Mill Bottom Road therna: 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U,S. Armed Forces? Pages 1 and 2 should be flad within 72 hours after of health and Merchal hygiene, not of Health and Tale merked other than "natural", or ther any or other trauments event, the Medical Examines any or other trauments event, the Medical Examines. 1 Yes 2 No If Yas, Giva X Year or Detes: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: À 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middla, Last) Be Earl W. Gledhill Margaret C. Durkin 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) William Hagner/Son 123 Warrington Way, Malvern, Pennsylvania 19355 20b. Place of Disposition (Name of cornetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dec 28 Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) West Laurel Hill Cemetery 2000 Bala Cynwyd, PA 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave.

Bethesda, Maryland 20814-3501

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast,

Approximata Approximata Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) 5 MPHYSEMA UNKNOWY Examiner Due to (or as a consequence of): Examiner 2 DATS LNEWSCHO MYOCARDIAL The law requires that the deeth certificate be assecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the buria Box 68760, Physician/Medical Due to (or as a consequence of): US0 85 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Nonknown HYPERTENSIO-Records, þ 68 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed MYASTITENIA GRAVIS completion of causa of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No of Vital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 10 1 Yas 2 No After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Division 1 Matural 5 Pending invastigation 1 | Yes 2 | No death. 2 Accident after deatl 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 12-25-CT D39037 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MITCHELL ANNE ARUNDEL MEDICAL CENTUR Amirroup 2006415

State Registrar

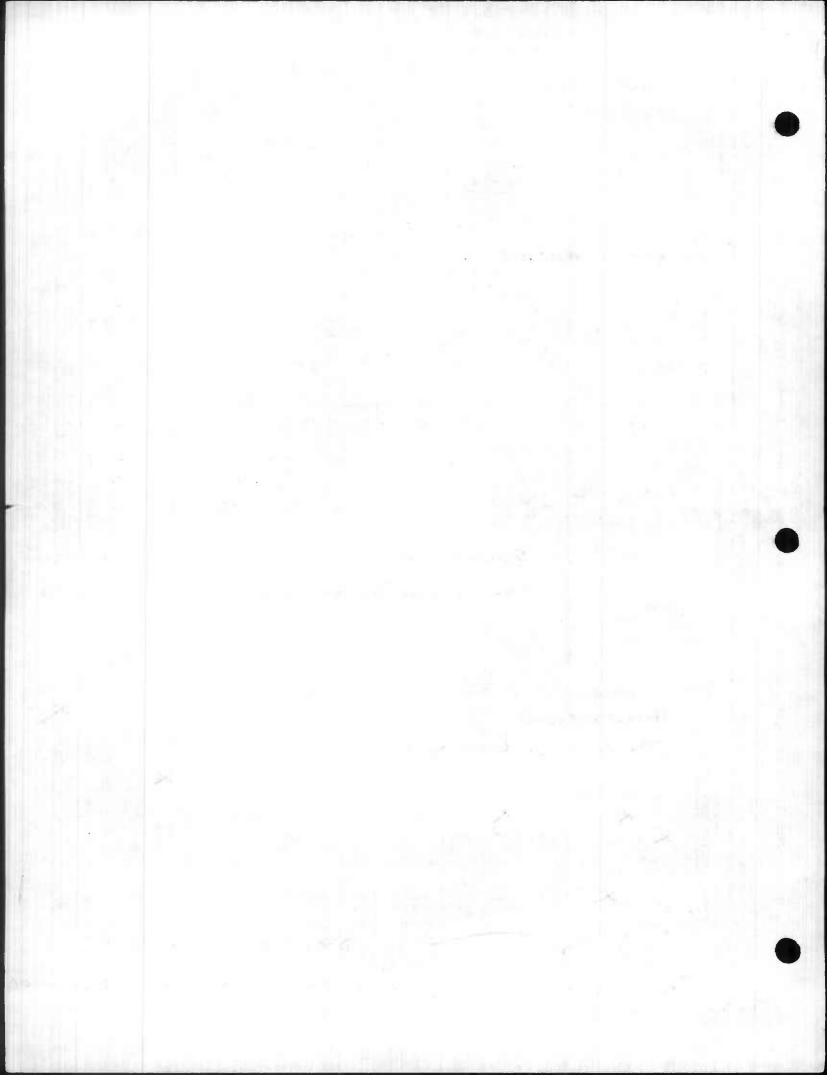
31. Date filed (Month, Day, Year)

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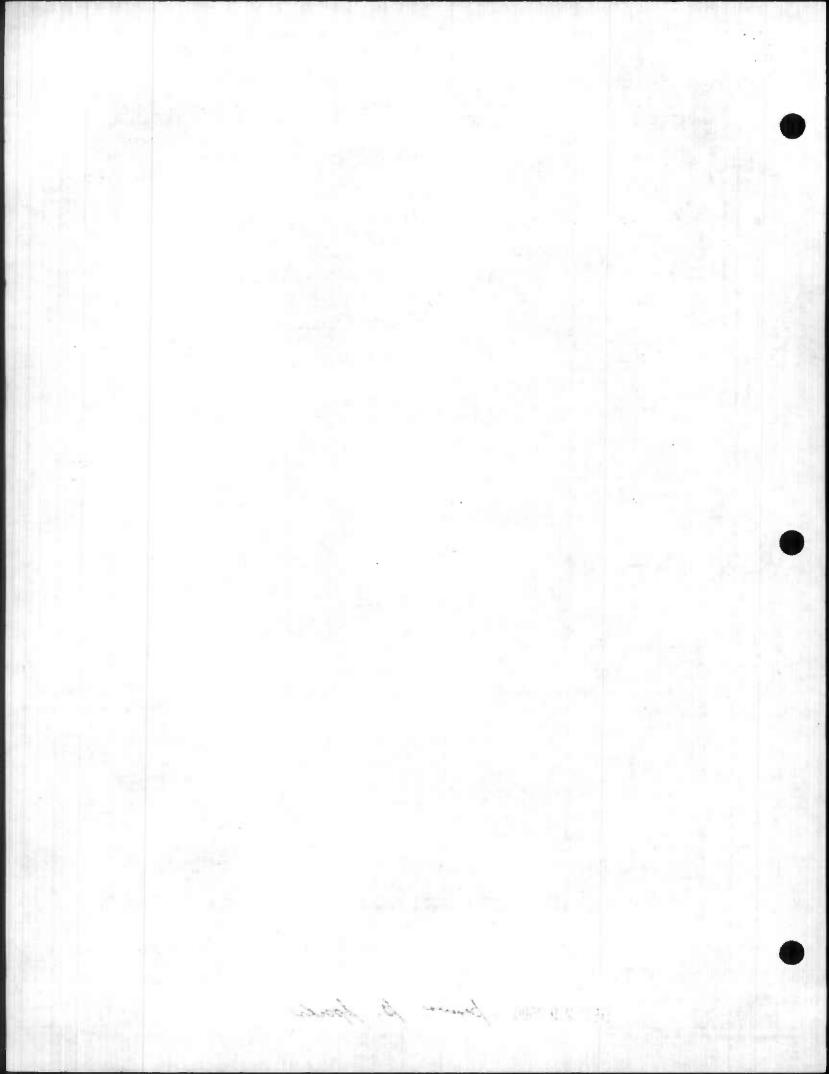
32 Registrar's Signature

perso



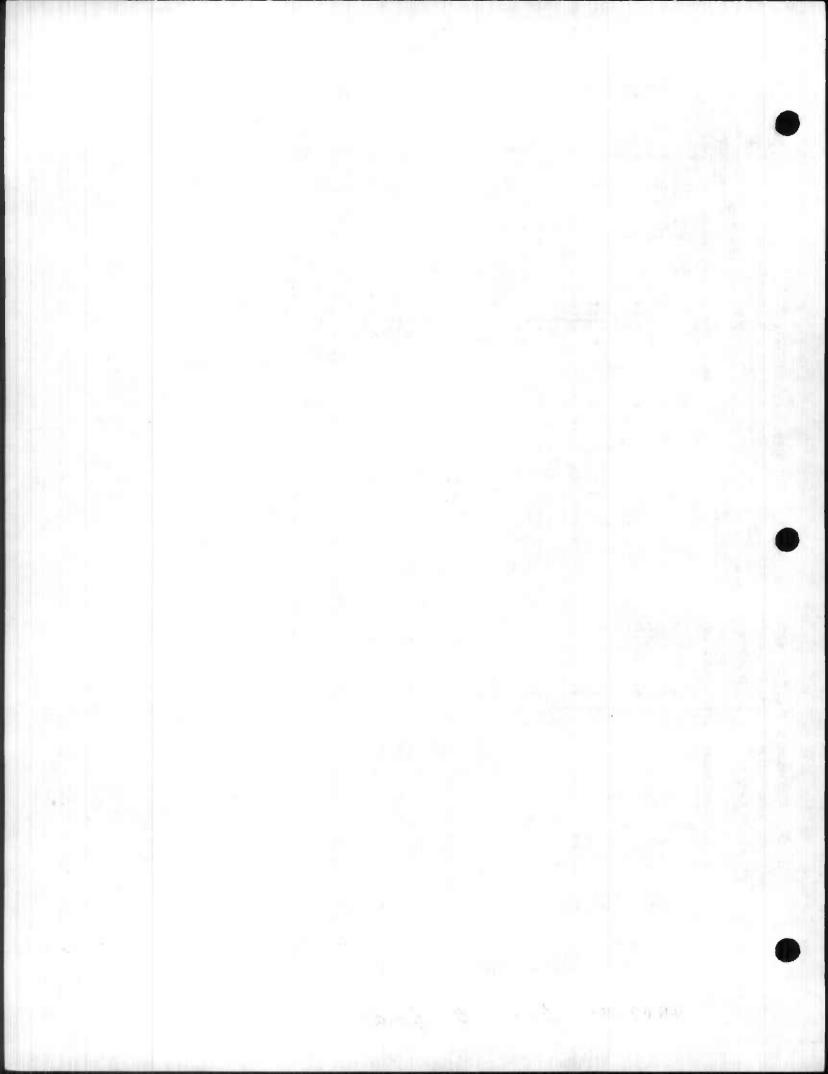
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JA	UDREY		4 Danielania Nama / Can Middle 1		Ce	rtificate of	f Death	1	Reg. No.			
	Physicia /Medic	n al	Decedent's Name (First, Middla, La     THOMAS	LEROY	LEROY JOUDREY			2. Data of Death Month Day DECEMBER 24, 20		Yaar 00 9:3	OA.M.	
	Examin	er	4a Facility Nama (If not institution, giv				4b. City, Town, or	Location of Death				
ŀ	Funeral		6203 SKYLINE TERF  5. Social Security Number 6. S		s. last birthday)	If Under 1 Yaa	SUITLAND or If Under 24 Hrs.	8. Data of Birt (Month, Da			GEORGES Birthplace (State or Foreign Country)	
L	Director			M 2□F 50	Yrs.	Months Day	s Hours Min.	January		O Panama	a	
	72 hours after death with the Maryland natural, or items 23a or 28e-f show final Exercitive months incidited	tor	10a. Stata 10b. County  Maryland Prince	e George's	City, Town or Lo Suitlan						de City Limits Yas 2\ No	
	or 28	Sire.	10e. Street and Number	Manager F.	1 200	10f. Zip Coda			10g. Citizan of V			
	23a	rai	6203 Skyline Ter				746		U.S			
98	or items	/ Funeral Director	11. Marital Status 1 ☐ Navar Married 2 ☐ Married	12. Was Decedent Evar in Armed Forcas?  1 X Yas 2 No 1 If Yes, Giva	060	13. Was Decedent of Hispanic Ongin? (\$\frac{1}{2}\text{if Yas, specify Cuban, Maxican, Puar}}{1 \sum \text{Yas 2 \text{\text{M} No Specify:}}}		(Specify Yes or No- irto Rican, atc.)  14. Re BI		ace - Amarican Indian, ack, Whita, atc.		
000	hours ural',	d by	3 ☐ Widowed 4 🂢 Divorced	Yaar or Datas: 1	975							
21215-0036	c .	Completed	15. Decedent's Elemantary/Secondary (0-12)	collega (1-4or 5+)	(Giva lifa.	dant's Usual Occ kind of work don DO NOT usa retii 'Penter	upation a during most of wor red)			nstructi	on	
	電工者を	BeC	17. Fathar's Nema (First, Middla, Last,	)	Out	pencer	18. Mother's Nan	ne (First, Middla,				
/lar	uld be Vental rked c	은 일	Gilbert Charles	Newton Joud	rey		Lenor	e Irene	Schick			
Maryland	alth end ? 27 is ma or traums		19a. Informant's Name/Ralationship ( John Joseph Joudy	**			Frederic				20637	
Baltimore,	t of He		20a. Mathod of Disposition		. Place of Dispo camatary, cra	osition (Nama of matory or other p	/aca)	Data	20c. Location -	City or Town, Sta	ta	
tim	Pe Int.		1 Burial 2 M Cremation 3 Ramoval from State 4 Donation 5 Other (Spacily) Huntt Crematory 12-29-2000 Waldorf, Marylan									
Bal	Departm Departm Importar any Injur		21. Signature of Flyneral Sarvice Lice	recit	2	2. Nama and Add The Hunt	rass of Facility t Funeral	Home, 1	Inc.			
P	mew	-	23a. Part1. Entar tha diseasa, or com shock, or haart failura. List only	SLEY MO11	54	P. O. Bo	x 156, Wa	Idorf, N	Maryland		ximate	
	Physician /Medical Examiner	Examiner	Immediata Cause (Final diseasa or condition resulting in death)  Sequentially list conditions,	Due to	(or as a conse	quance of):	CARDI	OVASCUL	ANDIS	LASE	and Deeth	
20,	0 0 5	-	if any, laading to immediate cause. Entar Undarlying Cause (Disease or injury	C						1		
× 6876	deeth certificate be e attending physici ed for use as the bu	Physician/Medica	that initiated evants resulting in death) Last		(or as a consec	quanca of):						
Вох	attend for us	clan						l ent mid				
P.O.	4 % 0		Part II. Other eignificant conditions of	onthouting to death but not r	esuring in tha u	indanying causa (	gwan in Part I.		Yee 2 No	ntribute to the ca	Unknow	
Records,		Completed by				1.201			an autopsy rmed?	24b. Were auto available p complation of daath?	opsy findings prior to n of causa	
R	The lay	E						1)231	Yes 2□No	1 Was	2 No	
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Divi	tal or Attanders after deat al Director: led in by the	Certif	3 ☐ Suicide 6 ☐ Could not b 4 ☐ HomicIda datarmined		homa, farm, st cify)	reat, factory, offic	•	28f. Location (: City or To		ber or Rural Routa	Number,	
	Hospi 24 hou Funer staly fill	edical		ysician: To tha best of my k niner: On tha basis of axami and mennar stated.							use(s)	
	To the To the compli	Ž	29b. Signatura and title of certifier	0	0		nsa number	1000		d (Month, Day, Ye		
			//	t, M.			C.M.E.	1	DECEMBE	R 25,2000	)	
			30. Name and addrass (if person who	completed causa of death (to			Street,	Baltimo	re, Mary	yland 212	201	

State Registrar



State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 4a Facility Name (If not institution, give street and number) 29, /Medical December 2000 1:12 PM 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Fintstone
If Under 1 Year If Under 24 Hrs. 8. Dat
Months Days Hours Min. (Mc 21300 Warm Springs RD Allegany 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1□ M 2 F Yrs. West Virginia Director 87 219-54-1542 Sept. 2, 1913 The Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No Directo ma 23e or 28a-f Maryland Flintstone Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21300 Warm Springs RD
12. Was Decedent Ever
Armed Forces? 21530 **USA** Funeral permit. Pages 1 and 2 ahoud be filed within 72 hours after dear Department of Health and Mental Hygiens.
Important: if item 27 is merited other in Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status ent Ever in U.S. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: by 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blaine Teeter Cora A. (Shreve) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21300 Warm Springs RD, Flintstone, MD 21530 Don H. Jackson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Glendale Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/31/00 Flintstone, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility **Kight Funeral Home** 309-311 Decatur St., Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ADENOCARCINOMA OF COLOR 1 YEAR 3 Many Examiner Physician/Medical Examiner The law requires that the death certificate be axecuted attending physician and for use as the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) of Vitai Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown ARTERY à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed if or Attending Physician: The law after deeth.

Director: After this certificate has d in by the funeral director, page 2: 1 Yes 2 No 1 Yes 2 No Medical Certification: To Be 25. Was case referred to medical 26. Place of Deeth (Check only ope) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 1No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investiga 1 Naturel 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerei C completaly filled Hospitai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated. 29b. Signature and the pr certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN 3 of person who completed cause of death (Item 23a) (Type, Print) 912 STON PRIVE CUMBERLAND MD USOZ MD 10SE This - WIFREA SR. 31. Date field (Month, Day, Year) 32. Registrar's Signature JAN 02 2001 Registrar oaks



### Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth 1 Month Day2 000 aar 21 7;45 AM **Physician** RENEE S. JANSE /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner MONTGOMERY POTOMAC VALLEY NURSING HOME ROCKVILLE If Under 1 Yaar | If Under 24 Hrs. Data of Birth 9. Birthplaca (State or Foraign Country) OLAND 7. Age (In yrs. last birthdey) **Funeral** Deys Months Hours 10 M 20 F 579-62-6629 97 Yrs Director Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-t show 1 XYes 2 No MONTGOMERY ROCKVILLE MD. Funeral Director must be notif 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Harns 23s or 1235 POTOMAC RD. 20850 U.S.A. 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: WHITE 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yas, Giva Yeer or Detes: 1 Never Married 2 Merried ъ Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) RESEARCH ANALIST N/ A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Be Pages 1 and 2 should be next of Health and Mental MATILDA FINMAR SEMYON SOKOLSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Important if item 27 is a sny injury or other in 10401 GROSVENOR PL. #530 ROCKVILLE MD. 20852 IRINA DOBRAY (NIECE) 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State Data 20e. Mathod of Disposition 1 Buriel 2 Cremation 3 Removal from Stete 4 Donetlon 5 □ Othar (Specify) GEORGETOWN MEDICAL 12/22/OOWASHINGTON D.C. 21. Signature of Funaral Sarvice Licansi 22. AND SOTO PONTOS ROPY CONTER FUNERAL HOME 3821 14th ST. N.W. WASH. D.C. 20011 23a. Pert1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause or each line. Approximete Interval Between Onsat end Death Physician Immediata Causa (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician sthe burial Medical Due to (or as a consequence of):

The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Diractor: After this certific completely filled in by the funeral director,

Baltimore, Maryland 21215-0020

Pert II. Other significant conditions con					23b. Did tobacco use cor	ftribute to the cause of death?	
		ar _ 7 - 4 - 4 - 4			24a. Was en eutopsy performed?	24b. Were eutopsy findings aveilable prior to completion of cause of death?	
25. Was case referred to medical			26. Plece	of Death (	Check only one)		
examiner? 1 ☐ Yas 2 ☑ No	Hospitel:	ER/Outpetient 3	DOA Other: 42 Nu	rsing Homa	5 ☐ Residenca 6 ☐ Oth	er (Specify)	
27. Menner of Death  1 1 Natural 5 Pending 2 Accident Investigation	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?		d. Describe how injury occurr	red	
3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Placa of Injury - At h building, etc. (Speci	ome, farm, street, fac	28	28f. Location (Street and Number or Rurel Route Number, City or Town, State)			
					d due to the cause(s) end ma at the time, date end place,		
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State Registrar

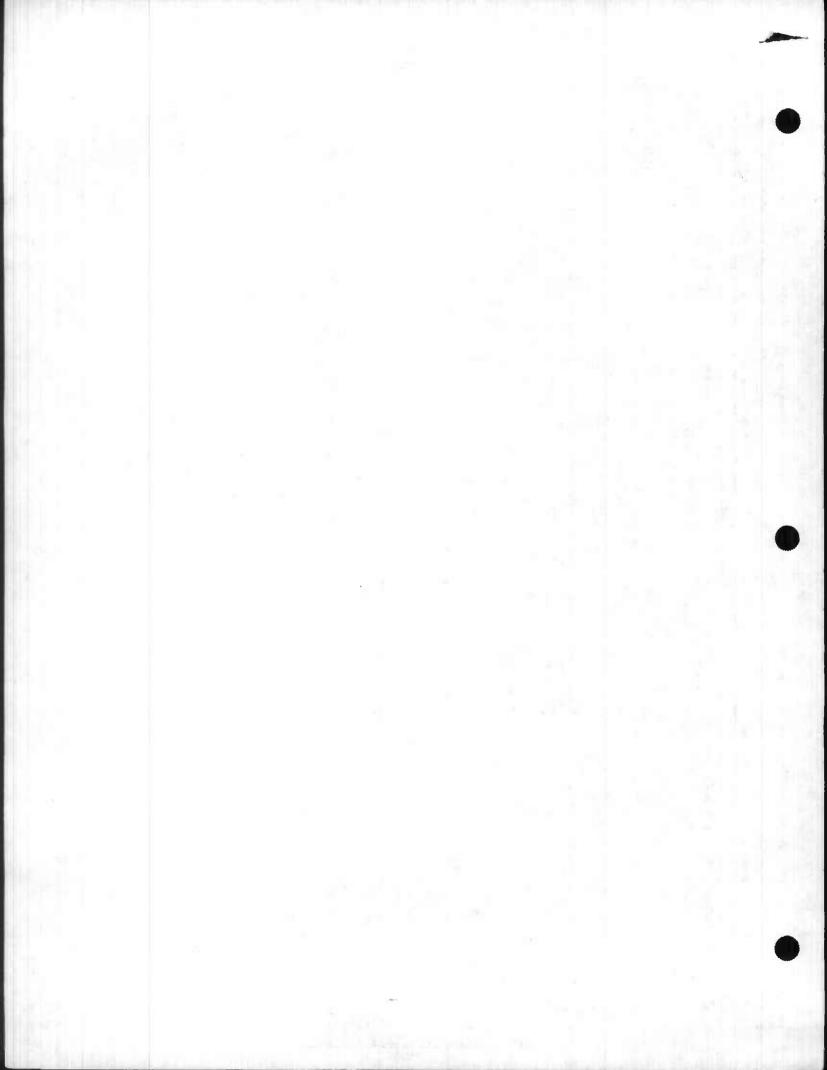
Ona

30. Name and addrass of person who completed causa of death (Item 23e) (Type, Print)

CA, ROCKVILLE MD 20850

D23958

2000



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Day Yaar 820 Rthuretta 212000 ecember 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nema (If not institution, giva street end number) If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) July 5 1948 more PAIS If Undar 1 Yaer Months Deys Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) 10 M 20 F 177-40-1835 52 Pa. Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. Counts 10d Inside City Limits Va. Fairfax Springfield 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 22152 7130 Rolling Forest Avenue USA 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑No If Yes, Give Year or Detes: Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 Nevar Married 2 Married specify.White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondery (0-12) College (1-4or 5+) teacher education 18. Mother's Nama (First, Middle, Maiden Surnema) 17. Father's Neme (First, Middle, Last) Arthur Brown Margaret Antill 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Ronald Kononchik (spouse) 7130 Rolling Forest Ave., Springfield, Va. 22152 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) All County Cremation Serv 12-23-00 Sykesville, Md 20a. Method of Disposition 1 ☐ Buriel 2 X Cramation 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signeture of Funerei Service Licensee I Daight Height Spiret P.O. Box 195 Sykesville, Md 21784 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RHRS Dua to (or as a consequence of): Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Due to (or es a consequance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Ware eutopsy findings evailable prior to 24a. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1□Yes 2□No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpetient 3 DOA 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending Invastigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, straet, factory, office building, etc. (Specify) 4 Homicide

Examine that the death certificate be executed attending physician and for use as the bunal-transit Physician/Medical USB as t signed by the a ģ Completed pege 2 s certificate has Be To After this funeral Certification: edical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Director

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permit. Page Department of Important: If any Injury or once.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral

> State Registrar

29a. Certifier

(Check only one)

29b. Signature end title of certifie

M. D.

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete and plece, end due to the cause(s) end menner stated.

29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

22 Sous Lalit

31. Dete filed (Month, Dey, Year) 32. Registrer's Signature

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ORIGINAL

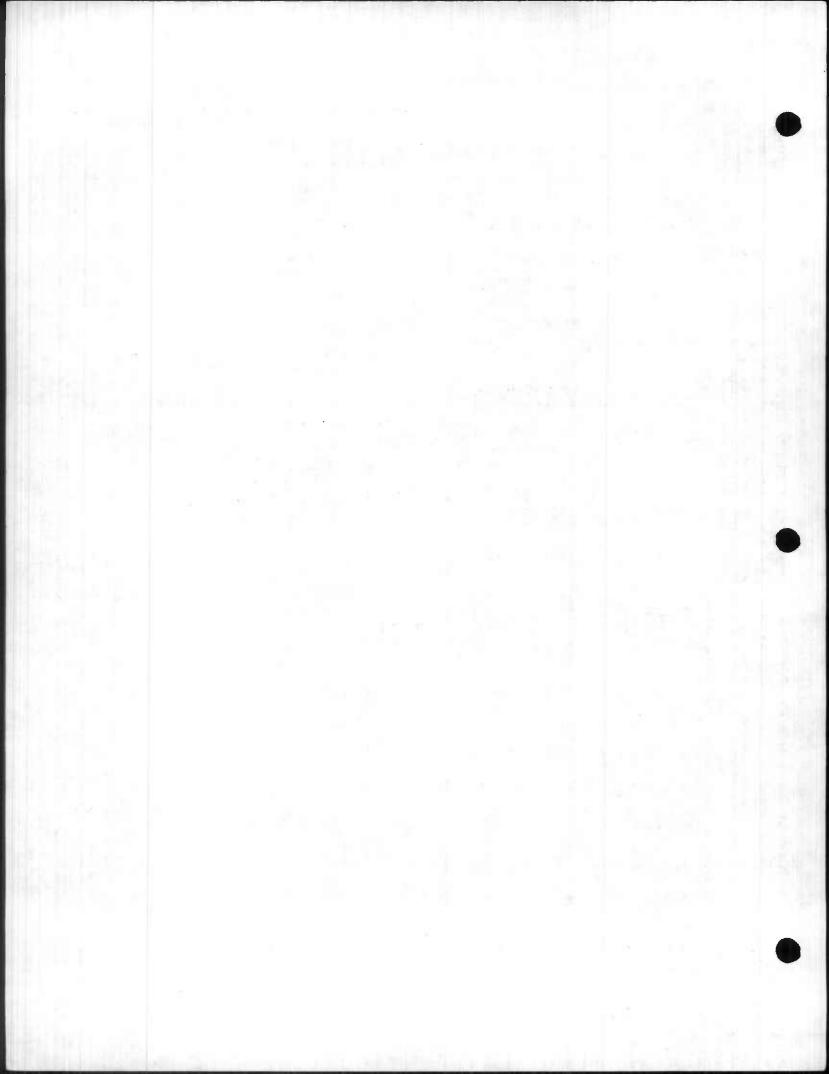
**DHMH 16 Rev 6/95** 

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# Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Zbigniew S. Kowalski December 21, 2000 5:45 pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Warm Care Potomac If Under 24 Hrs. 8 If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1⊠M 2□ F Vrs Director Poland 054-28-0750 **Usual Residence of Decedent** the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No Directo 28a-f Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or United States 6742 Kenwood Forest Lane 20815 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 72 hours after 1 ☐ Yes 2 🖾 No If Yes, Give Year or Detes: 1 □ Never Married 2 N Married 21215-0020 b 1 Yes 2 No Specify: of 2 should be lited within 72 hours at lith and Mantal Hygiene. 27 is marked other than "natural", or I traumatic event, the Medical Exam Specify à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Civil Engineer World Bank altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ant; if Item 27 is marked off lury or other traumatic even 8 Stanislaw Kowalski Helena Maldis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Kowalski/ Wife 6742 Kenwood Forest Lane Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 Ø Cremetion 3 ☐ Removal from State December 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Inc, 23, 2000 Bethesda, Maryland ROBERT A. Pumphrey Funeral Home/ Bethesda-Chevy Chase 17557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21 Signature of Funeral Service Licenses M00335 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about, or heart later. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Pneumonia 7 Days Examiner Due to (or as a consequence of): Examiner 2-3 Years Dysphagia physicien end the buriei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, 5 Years Rapidly Progressive Dementia Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown The lew requires thet signed to Hyperlipidemia, Hypertension Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Feeding Gastrostomy Tube (9/99) 1 Yes 2 No 1 ☐ Yas 2 ☐ No Vital Coronary Artery Bypass Graft 1980's Attending Physicien: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Group Home 1 Yes 2 No Certification: To o the state of funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division After 1 Natural 5 Pending investigation efter deeth. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 3 4 Homicide e Hospital or 1 24 hours effer Funerel Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fl 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00 70 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Miller, M.D. 6844 Tulip Hill Terrace Bethesda, Maryland 20816 31. Date filed (Month, Day, Year) 32. Registrar's Signature State senera DEC 26 Registrar

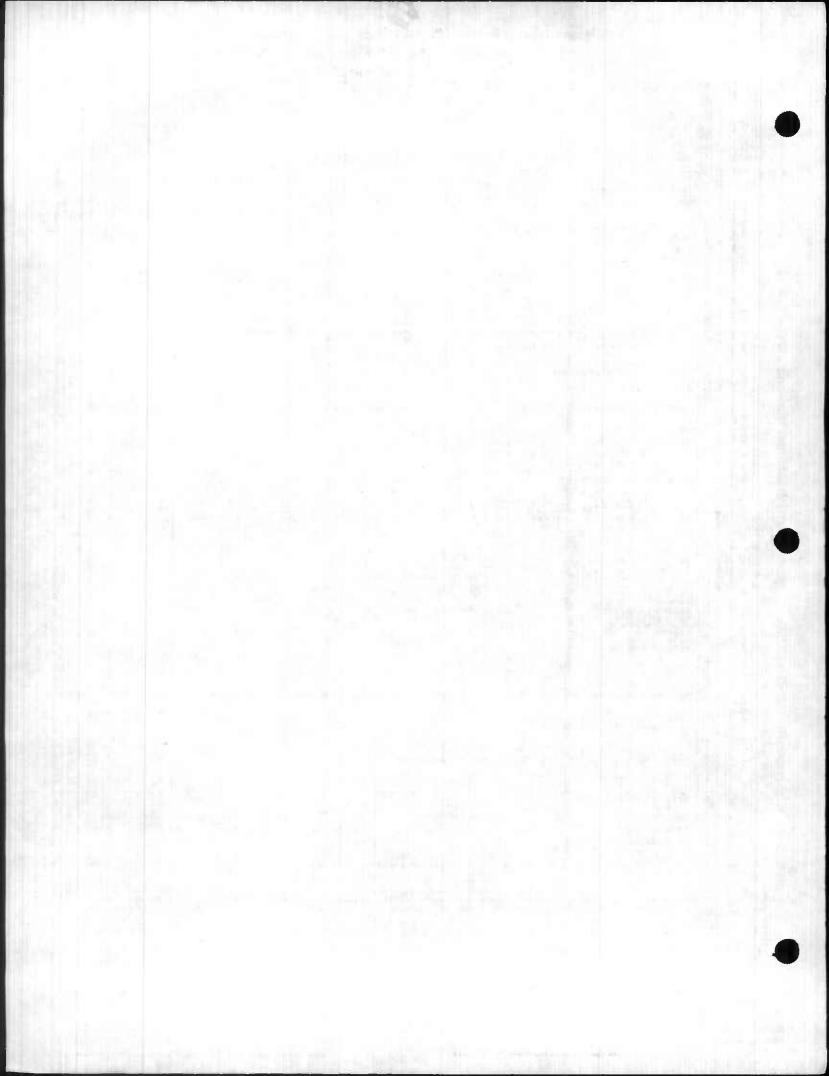
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

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	15		1 xmu	ATIT	P. KURU	HUAND		146	187	- D	EC EMBE	R 3	10 2000.	
			30. Name and address of person who	completed cause of d	leath (Item 23e) (	Type, Print)								
			ATIT P. KURUNIUL	1, u.s., 11	125 ROC	KVILLE	PIKI	E Ri	OCKVI	LE	MD	20	1852	
	Sta	te	ATIT P. KURUNIULA 31. Dete filed (Month, Day, Year) DEC 26 2	32. Begistr	er's Signatura	- 1					1			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #19b, 1/5/2001, GF, Montg.Co. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Dev **Physician** Selma Gintzler Klineberg 2000 Dec. 10:55 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8100 Connecticut Ave., #823 Chevy Chase Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Deys Yrs. 91 1, 1909 Director Nov. New York 113-36-3015 Usuel Residence of Decedent the Maryland 10a Stete 10h County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 1 No Maryland Directo Montgomery Chevy Chase 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? With 20815 8100 Connecticut Ave., #823 United States death v Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indien 11, Meritel Stetus Black, White, etc. 72 hours after 1 □ Never Married 2 □ Merried Baitimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White by 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) pernit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "yearlight or other traumatic avent, the 14-once. Elementery/Secondery (0-12) College (1-4or 5+) Home Maker Own Home 5+ 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Morris Gintzler Rose Fox 20 19a. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 15232 916 Bellefonte St., Pittsburgh, PA. 15132 Rosemary Coffey/Daughter 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory Inc. 12-30-2000 Beltsville, MD. 21. Signeture of Funerel Service Licensee

22. Name end Address of Facility
Rapp Funeral and Cremation Services,
Stephen D. Lohrmann P.A.
93 Gist Ave., Silver Spring, Md. 20

23a. Perl1. Enter the disease, or complications they clused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, 20910 Approximete Intervel Between Onset end Death **Physician** /Medical tmmediete Ceuse (Finel disease or condition resulting In deeth) 13 Months a Metastatic Breast Cancer Examiner Due to (or es e consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es e consequence of) Box 68760. Due to (or as a consequence of) resulting in death) Last 23b. Did tobacco use contributs to the cause of death? ed by the detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 0 signed t Records, by 24b. Were autopsy findings evaileble prior to completion of ceuse of deeth? been sig 24a. Wes en eutopsy performed? Completed has paga 2 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate Division of Vitai or Attanding Physician: Be 25. Was cese referred to medical 26. Place of Deeth (Check only one) Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5 Residence 6 □ Other (Specify) 10 1 Yes 2 No this funaral 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 (Neturet 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stefe) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) after 4 Homicide To the Hospital within 24 hours a To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner es stated.

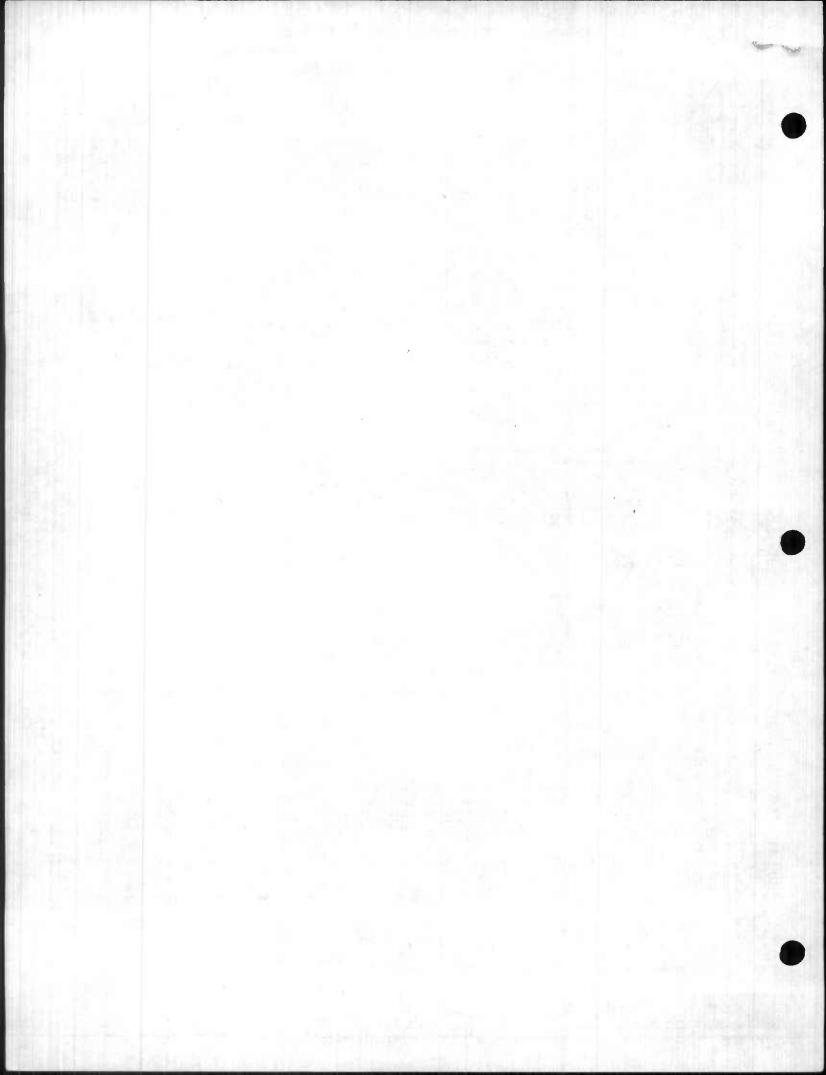
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner steted. edical 29a. Certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signafure end title of certifier D37236 December 26, 2000

12 State

Registra

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)
Dr. Carolyn B. Hendricks, M.D.; 6410 Ro Hendricks, M.D.; 6410 Rockledge Dr., ste. 305, Bethesda, Md. 20817 31. Dete filed (Month, Dey, Year) DEC 2 9 32. Registrer's Signeture

Frence oaks



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** KHADER NIALL December 19, 2000 ation of Deeth 4c. County of Death 2000 /Medical 4:50 P.M 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Prince George's Hospital Center Cheverly Prince George's 8. Date of Birth Jan 1,1976 If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Deys Months Hours Min 15 M 2□ F Egypt 458-37-1547 24 Yrs Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County hems 25s or 28s-f st her must be notified Maryland Montgomery Gaithersburg Yes 2 No Directo 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20253 Maple Leaf Ct. 20879 USA Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. the Medical Examiner 1 Yes 2 No If Yes, Give Year or Dates: Never Merried 2☐ Merried "natural", or 1 Yes 25 No Specify: Specify: Egyptian á 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within Elementery/Secondary (0-12) College (1-4or 5+) Unemployed None Hygie 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be Mental merked Sarwat Khader Marion Fitzpatrick and / 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) cartmant of Health an Important: If New 27 is a any Injury or other 2005. 20253 Maple Leaf Ct, Gaithersburg, Md. 20879 Marion Khader -Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Parklawn Memo. Park 12-22-2000 Rockville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Universal II Mortuary Inc. 21. Signature of Juneral Service Licenses 411 Kennedy St, N.W., Washington, D.C. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examiner law requires that the death certificate be executed ettending physicien and for use es the bunal-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 **Physician/Medical** Due to (or as a consequence of) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed t Š cate has been significant categories categor 24b. Were autopsy findings eveilable prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed The 2 No certificate Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) 1 √Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir 28g. Describe how injury occurred sufficiently during pearly that wall 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 5 Pending investigation Attending 1 Naturel after deeth.

Director: Aft
d in by the fur 1 Yes 2 No 1835 HK nd 12/18/00 2. Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6,200 Block Pain 4 ☐ Homicide ò Brack Park College Ports.

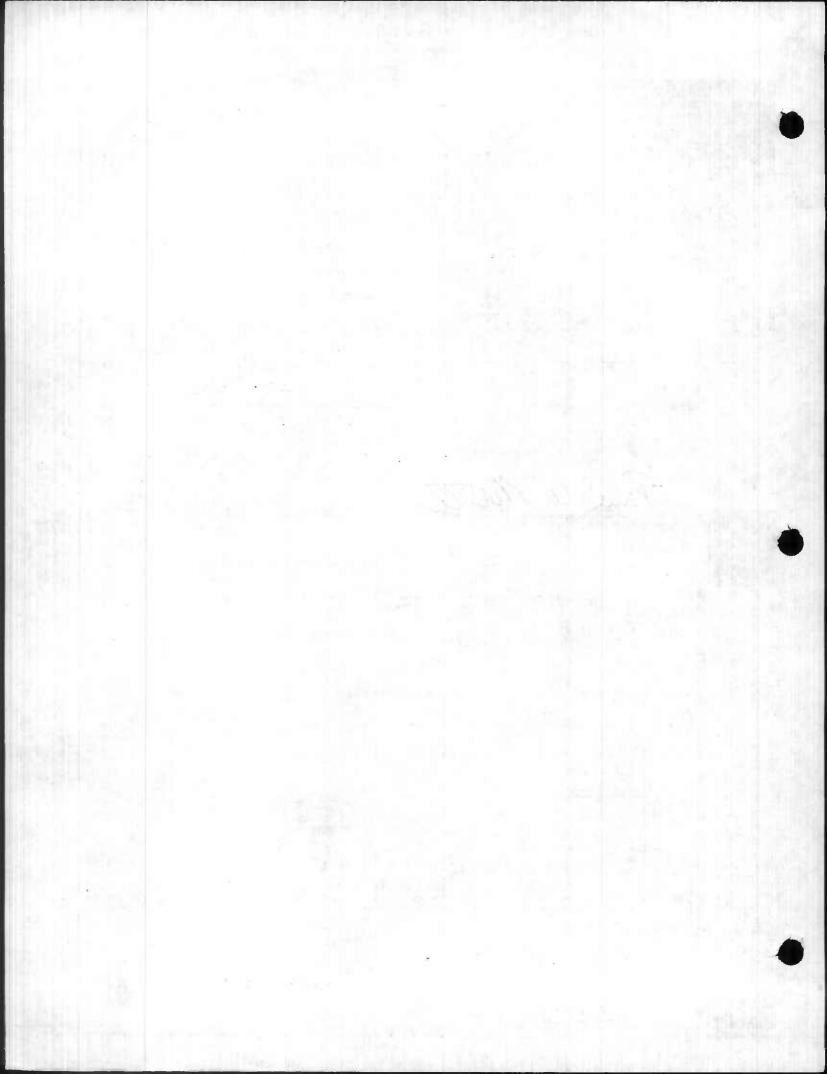
1 Certifying Physician: To the best of my knowledge, death occurred of the time, date and place, end due to the cause(s) and manner as stated. Many for my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospital of within 24 hours af To the Funeral Dicompletely filled in 29e. Certifier edicai (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 20, 2000 preador 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 THEODORE M.H. 31. Date filed (Month, Day, Year)

State Registra

**DEC 27** 2000

32. Registrar's Signeture

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death December 19, Harry Reimer Leonard 2000 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Carroll County General Hospital Westminster Carroll 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) 10 M 20 F Months Days Hours Yrs. 219 10 3894 March 23, 1924 Md. Usual Rasidance of Dacedani 10a State 10h County 10c. City, Town or Location 10d. Insida City Llmits Md. Carroll Svkesville 1 ☐ Yes 2 ☑ No 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 7200 Third Ave. 21784 U.S.A. 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 22☐ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2□No Specify: Specify: White 3€ Widowed 4 Divorced 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Westinghouse Corp. Elamantary/Secondary (0-12) Collega (1-4or 5+) Electrical Engineer +4 18. Mother's Name (First, Middle, Malden Sumame) 17. Fether's Neme (First, Middle, Last) Irving Cofran Leonard Louise Jones 19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Coda) Lance L. Leonard - Son 410 Hazlett Ave. Baltimore, Md. 21229 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burlal 2 【Cremation 3 ☐ Removal from State All County Cremation Srv. 12/22/00 Sykesville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licanses 22. Name and Address of Facility Haight Funeral Home & Chapel P.O.Box 195 Sykesville, Md. 2178 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or health ailure. List only one cause on each line. Approximeta Intervel Between Onset and Death Artery Immediate Ceuse (Final disease or condition resulting In deeth) Coronery Sequentially list conditions, if any, laading to immediate causa. Entar Underlying Cousa (Diseasa or injury that initiated events resulting in daeth) Lest Dua to (or as a consequence of): Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? Pulainsons 3 Probably 4 Unknown 1 Yes 2 No 24b. Wera autopsy findings available prior to completion of cause of daath? 24e. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case raferred to medical axaminar? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 1 Natural

the death certificeta be axecuted physicien and the burial-trans attending pl signed by the a has page 2 cartificate

Examiner Physician/Medical by Completed funaral director, Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

r 28a-f show

Pegas 1 and 2 should be filed within 72 hours after death with I nent of Hauth and Mental Hygiena. Int: If Item 27 is marked other than "natural", or Items 23a or inty of other traumatic event, its Modest Essistics marke

permit. Pegas Department of Important: if it any injury or o

**Physician** 

Examiner

/Medical

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

the Maryland

Division of Vital Records, P.O. Box 68760. Hospital or Attanding Physician:
 24 hours after deeth.
 Funeral Director: After this carifics in by To the Hospital or within 24 hours aft To the Funeral DI completely filled in

29a, Certifier (Check only one)

2 Accident

3 ☐ Suicide

6 Could not be determined 4 Homicida

28a. Data of Injury (Month, Dey Year) 5 Pending investigation

28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

Contra Dr. Reinfortono, MD

29b. Signeture end title of certifier Roll J. Mon,

MD

29c. License number

29d. Date signed (Month, Day, Year) 12/20/00

30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Businer Mals 6.

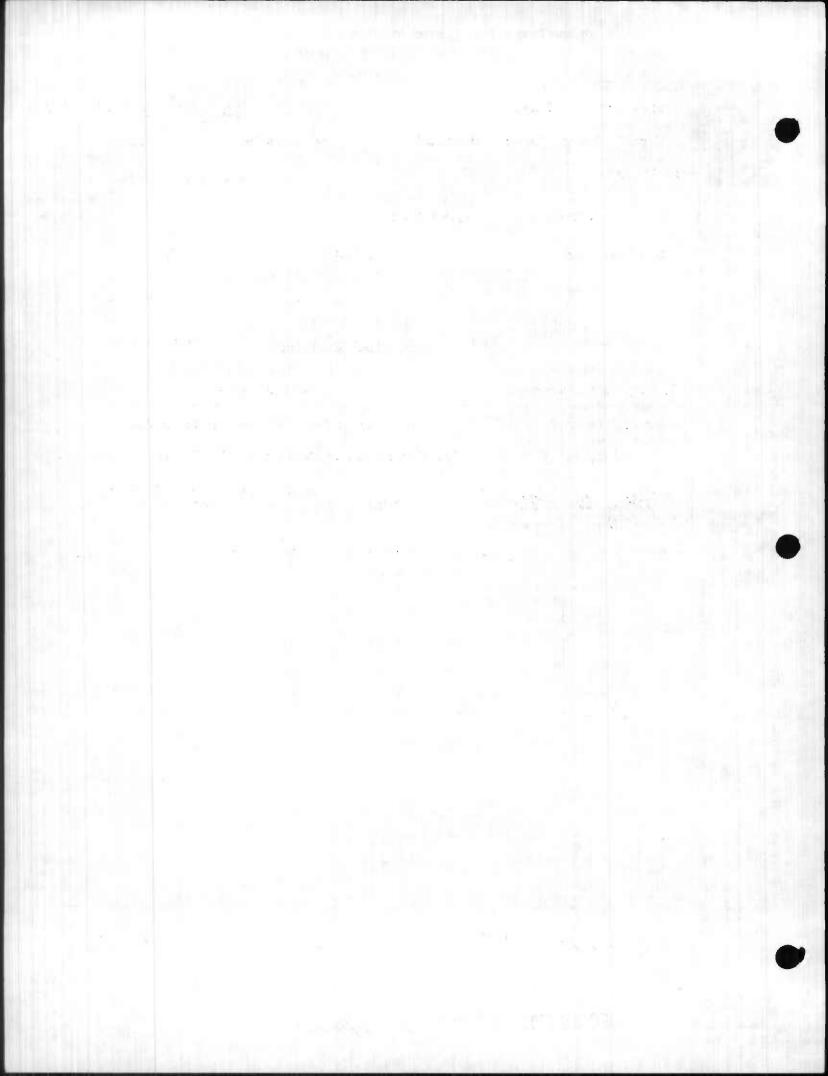
31. Dete filed (Month, Day, Year)

32. Registrer's Signeture

Registrar

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**DHMH 16 Rev 6/95** 



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Month Day Year **Physician** Jacob Ryle Long Dec 26 2000 0035 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Westminster

| Munder 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) Carroll County General Hospital Carrol1 5. Sociel Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 10 M 20 F **Funeral** Months Deys 73 Director 219-20-3678 May 25 1927 Usual Residence of Deceden 10d. Inside City Limits 10a. Stata 10b. County 10c. City, Town or Location Nerve 23a or 28a-f show ner must be notified at 1 Yes 2 No Directo Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1315 Woodland Drive 21157 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Detes: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexicen, Puerto Rican, etc.) other than "natural", or lien Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify ğ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry pennit. Pages 1 and 2 should be filled within 72. Department of Health and Mental Hygiene, importants if them 27 is merited other than "nets any injury or other traumetic event, the Medical addiss. 15. Decedent's Education (Specify only highest grede completed) Canga leum Elementery/Secondery (0-12) College (1-4or 5+) Laborer Industries 11 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Nama (First, Middla, Last) charles W. Long Etta Belle Tawney 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Charles D. Long/brother 1315 Woodland Drive Westminster, MD 21157 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Buriel 2 Cremetion 3 Removal from State Carrollton Cemetery 12/29/2000 Finksburg, 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility
Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD21157 that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximete Intervel Between Onsat end Death **Physician** Immediata Ceuse (Final disease or condition resulting in death) /Medical 1.Cafj Examiner Due to (or es e consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) rasulting in deeth) Last ed by the s 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown signed b by 24b. Were autopsy findings available prior to completion of ceuse of death? been significant 24a. Was en autopsy performed? Completed page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: director Be 25. Wes cese referred to medicel 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 2 12 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28d. Describe how injury occurred Certification: Injury et Work? After 5 Pending investigation Neturel 1 Yes 2 No death. 2 Accident Director: / 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stele) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital
within 24 hours a
To the Funeral C Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and menner steted. 29e. Certifier edicai 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) alexan D6052815 2000 Ser 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) M.D. 686 Poole Road Westminster, MD 21157 Alexander, 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Senera Registrar DEC 2 7 2000

DHMH 16 Rev 6/95

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2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Is marked other than "natural", or Itema 23a or 28a-f show reumatic event, the Hederal Exercises main to reother a reumatic event, the Hederal Exercises main to reother a To Be Completed by Funeral Director	Usuei Residence of Decedent  10a. Stete 10b. County  MARYLAND MONTGO	MERY	10c. City, To	cation PARK			0d. Inside City Limits 1 ☐ Yes 2 🏋 No					
	10e. Street and Number 1202 HOLTON LANE	10f. Zip Code 209	12		100	g. Citizen of	What Coun	itry?				
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permit Pages 1 and 2 should be filed within 72 hours Construent of Heelth and Mental Hygiene. Important: If flem 27 is merked other than "natural; any injury or other treumatic event, the Head all Euler To Be Completed by	PETER LUCK  19e. Informent's Neme/Reletionship (Type, Print)  OLGA LUCK / WIFE  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 1202 HOLTON LANE, TAKOMA PARK, MARYLAND										Code) 20912	
Pages 1	20e. Method of Disposition  1 Na Buriai 2 Cremetion 3 Removel from Stete  4 Donetion 5 Other (Specify)  20b. Plece of Disposition (Name of cemetary, cremetary or other plece)  ST. ANDREW SUKRAINIAN ORTH. 12/28/00 NEW JERSEY											
Depart Depart Import any in	22. Neme end Address of FedhINES-RINALDI 11800 NEW HAMPSHIRE  AVENUE SILVER SPRING, MD 20904											
Physician /Medical	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.										Approximete Intervel Between Onset end Death	
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To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: After this certificial completely filled in by the funeral director, Medical Certification: To Be (	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 289. Piece of in	njury - At home, tc. (Specify)	ferm, stre	eet, factory, office	hL		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
in 24 hours in 24 hours he Funer pletely fill	29e. Certifier (Check only one)  1 Certifying  1 Medical E	Physician: To the basis of the	of examinetion	lge, deeth end/or inv	estigation, in my o	opinion, deet	d pleca, end du th occurred et t	e to the ceu he time, det	use(s) end m e end pleca	enner es s , and due to	stated. the cause(s)	
To within com	29b. Signeture end title of certifier		191		29c. Licens	8089		10	Date sign			

State Registrar

31. Dete filed (Month, Dey, Year)
DEC 2 9

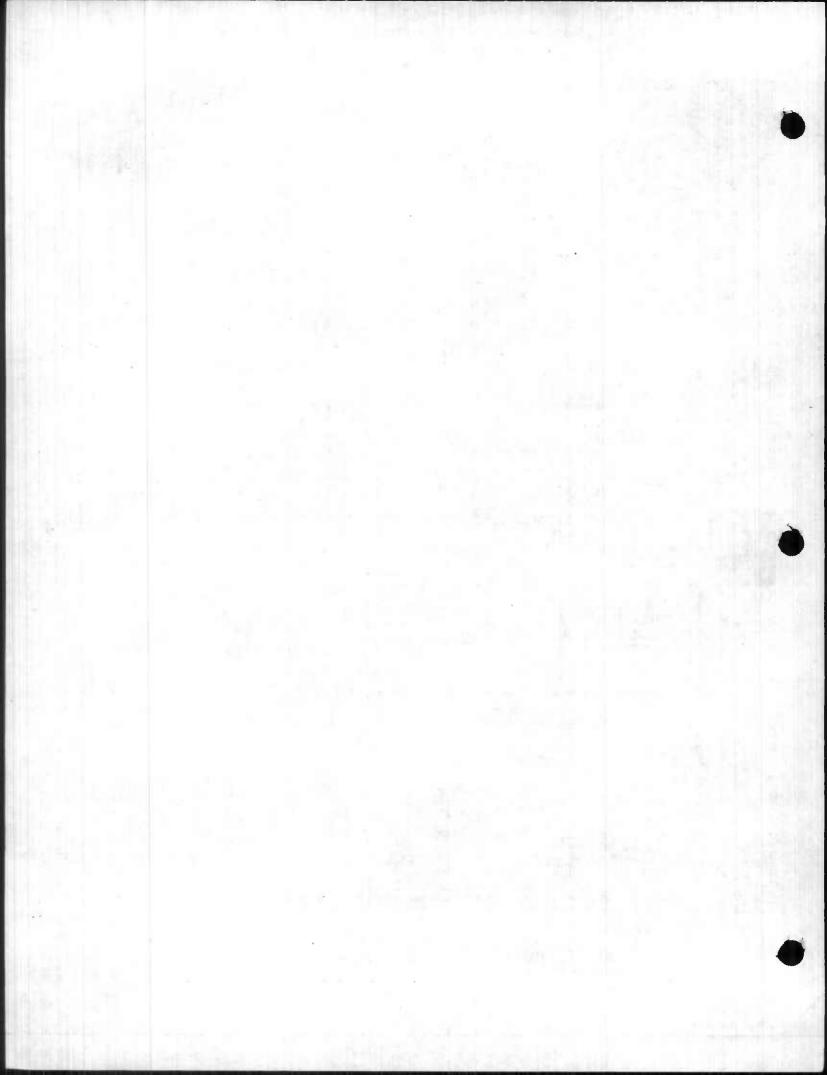
30. Name end address of person who completed cause of death (ttem 23a) (Type, Print) MICHAEL LEIBOWITZ, M.D. 11120 NEW HAMPS: 32. Registrer's Signeture

11120 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

Baltimore, Maryland 21215-0036

Physic /Med Exam

Division of Vital Records, P.O. Box 68760,



# Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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State   Stat		25. Was cese referred to medical 26. Place of Death	(Check only one)	)								
1   Natural 2   Accident 3   Suicide 4   Homicide   See. Place of Injury - At home, farm, street, fectory, office   28f. Location (Street and Number or Rural Route Number, City or Town, Stete)   29a. Certifier (Check only one)   29b. Signature and title of earlifier   29b. Signature and direct of person who completed cause of death (Item 23a) (Type, Print)   29c. License number   29d. Date signed (Month, Day, Year)   12 2 6 co. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   29c. License number   29d. Date signed (Month, Day, Year)   27 70   31. Date filled (Month, Day, Year)   32. Register's Signeture   4   Appullation   4   Appul	y y y c	Hospital: 1 Innetient 3 FD/Outpetient 3 DOA Other: 4 Nursing Hos	me 5 Aesiden	ce 6 Other (Spe	cify)							
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year December 23, 2000 **Physician** 11:30 PM Agnes Ann Lindberg /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery North Bethesda Brighton Gardens If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 17, 1923 9. Birthplace (State or Foreign Country) Missouri 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 F 77 Vrs Director 496-12-8592 Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23s or 28sf show entering or other traumatic event, the Medical Examples must be notified at page. 10e. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yas 2 No Director Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 4614 Coachway Drive United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forcas? 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Communications Analyst 12 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Kostka Blase Kovac 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3132 Stonehenge Drive, Riva, Maryland 21140 Eugenie J. Riordan/Daughter Baltimore. 20b. Place of Disposition (Name of cematery, crematory or other placa) Dec. 28, 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 Cremation 3 Removal trom State Parklawn Memorial Park Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2000 Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Ligensee M00198 20 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heer tailure. List only one ceuse on each line. Approximate Interval Between Onset and Daath **Physician** /Medical Immediate Cause (Final 1 Week Pneumonia diseasa or condition resulting in death) Examiner Due to (or as a consequenca ot) Examiner 1 Month Acute Myelogenous Leukemia The law requires that the death cartificate be executed attanding physician and for usa as the bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequenca ot): P.O. 23b. Did tobacco use contribute to the cause of death? ata has been signed by the paga 2 should be datached Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown Division of Vitai Records. þ 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? After this cartificate has 1 ☐ Yes 2 ₺ No 1 Yes 2 No Physician: funaral director. Be 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? upital or Attending Procus after death. 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Sulcida 28a. Placa ot Injury - At home, farm, street, tactory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral Complately filled in the Funeral Complately filled in the second seco 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certities December 26, 2000 D07285 20 , Brown, Mi mery 30 Number and address of person who completed cause of death (Item 23a) (Type, Print)

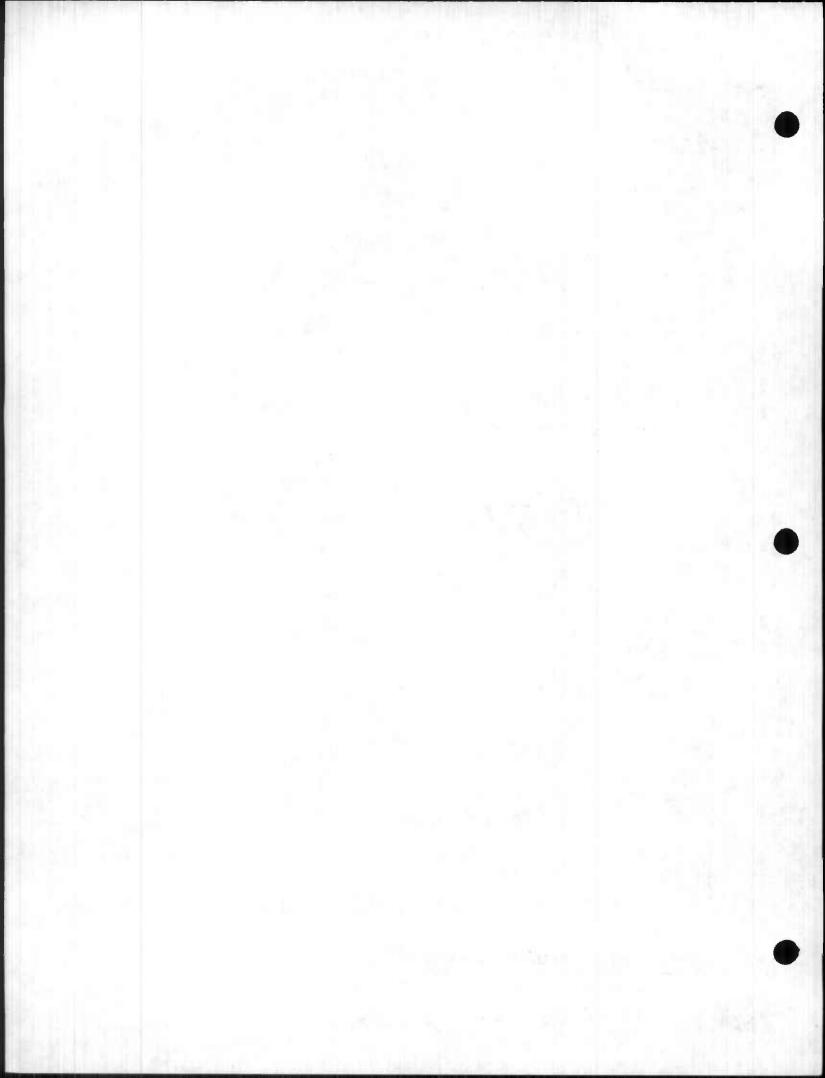
DHMH 16 Rev 6/95

State Registrar James A.

31. Date tiled (Month, Day, Year) DEC 2 7

32 Registrar's Signatura

Brown, M.D. 10605 Concord Street, Kensington, Maryland 20895



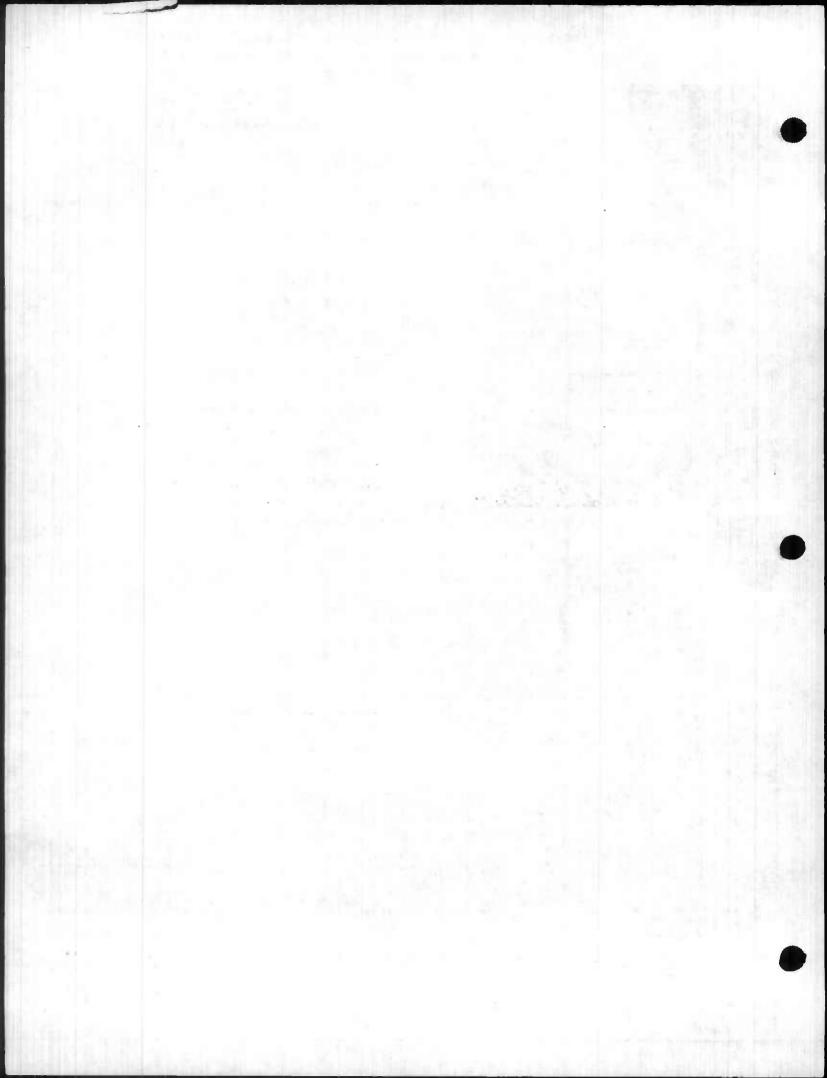
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State of Maryland / Department of Health and Mental Hygiene

			Certificate	of Death	R	eg. No.	42834				
Dhamisis	1. Decedent'a Name (First, Middle, Las	1)		2. Dete of Dee Month	3. Time of Death						
Physiciar /Mėdica	Nathan 1.10	der			Decembe	r 21, 2	000 11:00pm				
Examine	4a Facility Name (If not institution, give	The state of the s	4b. City, Town, or		4c. County						
	11615 College Vie			Silver S		Montg					
Funeral Director	5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 F 89 Yrs.  7. Age (In yrs. last birthday) Months Days Hours Min. Qctober 14, 1911 9. Birthg										
ahow	10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits				
h the Man r 28e-f ah r curied	Maryland Montgome		1 ☐ Yes 2 No								
death with the Manyand ms 23e or 28e-f show traust be notified at	10e. Street and Number	1	Og. Citizen of W	/hat Country?							
23a c	11615 College Vie	w Drive		20902		United	States				
5 2 2	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in to Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates Army /		nt of Hispanic Origin? (5 ry Cuban, Mexicen, Puer XNo Specify:	Specify Yes or No- to Rican, etc.)		e - Americen Indian, k, White, etc. : White				
nd 21215-003	15. Decedent's Ed (Specify only highest gra	ucetion	16a. Decedent's Usual	Occupation done during most of wo	deina	16b. Kind of Bu	siness/Industry				
within then then	Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	retired)							
illed within Hyglene.		5+	Statistici				Government				
X				Mollie	me (First, Middle, Hurtes	Maiden Sumam	€)				
Marylé d 2 should th and Mer 7 ls marke traumatic	19a. Intormant's Name/Reletionship (	ype, Print)	19b. Mailing Address	Street and Number or R	ural Route Numbe	r, City or Town,	State, Zip Code)				
	Michael Lieder /	Son		ale Terrace							
Baltimore, I permit. Pages 1 en Department of Healt Important: If Item 21 any Injury or other page.	20a. Method of Disposition  1 \( \Delta\) Burial 2 \( \Delta\) Cremation 3 \( \Delta\) Removal from State  4 \( \Delta\) Donation 5 \( \Delta\) Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  George Washington Cemetery 12/24/00 Adelphi, MD										
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Danzansky Goldberg Memorial Chapel, Inc										
	Monald C.	Stattleney		y Goldberg kville Pike							
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that ceused the	h Do not enter the mode	of dying, such as cerdia	c or respiratory arr	est,	Approximate Interval Between				
Physician							Interval Between Onset and Death				
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Cardiomyopathy										
			or as a consequence of):				Years				
be rist	Coronary Artery Disease										
P.O. Box 68760, that the death certificate be assecuted ed by the attending physicien and detached for use as the burial-transit	Sequentially list conditions, Due to (or as a consequence of): if any, leeding to immediate										
68760, ficate be a physician as the buria											
687 ifficate g phys											
Box 68 leath certifical attending phi for use as the control of th		d									
P.O. BO)	Part II. Other eignificant conditions of	entributing to death but not re-	23b. Did to	obacco use cor	ntribute to the cause of death?						
P.O. that the de detached				1 🗆 Y	3 Probably 4 Unknown						
S, Fe straight of the det	Benign Postatio	Hypertrophy									
Records, to law requires to has been signed to should be	Depression				24a. Was a perfor	n eutopsy med?	24b. Were autopsy findings available prior to				
Pecceler respectively	Bepression						completion of ceuse of death?				
The law requir	Hyponatremia				1□ Y	es ZE No	1 ☐ Yes 2 ☐ No				
Of Vital In Physician: Th this certificate ral director, par	25. Was cese referred to medicel			26. Place of De	eth (Check only or	ne)					
hyaic this co	1 ☐ Yes 2 → No		ER/Outpatient 3□ DO		dome 5 Resid						
Division of Vital or Attanding Physician: The affer death. Director: Affer this certificate of the funeral director, partitional dir	27. Manner of Death	28a. Date of Injury (Month, Day Year)		c. Injury at Work?	28d. Describe h	ow injury occurr	red				
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or Att free d lined in by	4 Homicide determined	28e. Place of Injury - At a building, etc. (Special	nome, farm, street, factory, ify)	office	281. Location (S City or Tow		er or Rural Route Number,				
C sale	N										
Division C  Mospital or Attanding P  To 24 hours after death.  Funeral Director: Attent pletely filled in by the funeral	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my kniner: On the basis of examinand manner stated.	owledge, death occurred a ati <i>on</i> and/or investigation,	t the time, date and plece in my opinion, death occ	e, and due to the c urred at the time, o	ause(s) end ma late and place, a	and due to the ceuse(s)				
Division  To the Hospital or Attant within 24 hours after dealt To the Funeral Director: completely filled in by the		and mariner Stated.	29c.	License number	2	29d. Date signed	d (Month, Day, Year)				
	· Mal	0 1			100						
10	20 Nome and			51724	D	ecember	22, 2000				
	30. Name and address of person who was Neelam Shah, M.		m 23a) (Type, Print) Connecticut A	we Kengir	oton MD	20895					
State				ive., Kensti	econ, rm	20033					
Registrar	31. Date filed (Month, Day, Year) DEC 2 7 20	10 Spieve	B. Spor	Ks							

DHMH 16 Rev 6/95

ORIGINAL



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 2835 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

**Physician** /Medical Examiner Director

1. Decedent's Name (First, Middle, Last) SOPHRONIA Month 12:4074 12. 2000 4a. Facility Name (If not institution, give street and number)
FOIRLAND ADVISURS WESING + RESTAB 4b. City, Town, or Location of Death Silver Speing HONTGOHBEY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)

1 3 - 1901 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 1 M 2 F UNKROWN 578-20-8293 the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "neturel", or items 23e or 28a-f show traumatic event, the Medical Examiner must be notified at HONTGOMBEY SILVER SPRING 1 Yas 2 No 10f. Zip Code 10g. Citizen of What Country? PAIRLAND PLACE U.S.A. 2101 nit. Pages 1 and 2 should be filed within 72 hours after death vertinent of Health and Mental Hygiene. ortant: if flear 72 is marked other than "natural", or itams 23, injury or other traumatic event, it a Medical Example men Funerai Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedant Ever In U,S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yas 2 No If Yes, Give Year or Dates; 1 Naver Married 2 Married 1 Yas 2 No Baltimore, Maryland 21215-0020 BLACK À Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation
(Give kind of work dona during most of working life. DO NOT use retired)

HOUSE WIFE 15. Decedent's Education (Spacify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) Je 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6534 WORTH CAPITOL ST NW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from Stata TOUS LINCOLN COMERCY 12 29.00 BUSHINDOD, ML LYIN (M-01257) 22. Name and Address of Facility BIANCHI FUNDIAL SERVICES HEMSTRUNG permit. Page Depertment of Important: If any injury or once. BEENTWOOD, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Partoson 814 UP3 We 35 NW; WASHNGNW, OC 26011

art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel PROSEPSIS disease or condition rasulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Lest physician and the bunal-tran Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by the ALZHEIMERS DEMENTIA 1 Yas 2 No 3 Probably Unknown Records. by Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? ATERIOSCHEROTIC CARDIOVASCULAR DISBASE completion of ceuse of death? page 2 s HETHEITIS 1 Yes 2 No 1 Yas 2 Wo Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certification of the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director director directors and directors directors. Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) DECOMBOR 27, 2000 D41931 3 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
R. SHUMACHEL, MO 2309 ShoreField Roxo Wheatow, MO R. SHUMACHDE, MD 31. Date filed (Month, Day, Year)

Registrar

DEC 29 2000





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# Piease Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day Yaar **Physician** Gertrude Buckley Lawler 26, 2000 9:05 am December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Laurel Regional Hospital Laurel
If Undar 24 Hrs. Prince George's If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) 6 Say **Funeral** 1□M 20 F Months Days Hours Min. Yrs. 92 Director 215-44-3395 Oct 26, 1908 Virginia Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yas 2 No Director Maryland Montgomery Silver Spring fig. 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? iene. "rustural", or lients 23s or the Medical Examiner must be n 14000 Castle Boulevard #507 20904 Funeral USA 12. Was Decedent Evar in U,S. Armed Forcas?

1 Yas 2 No
If Yas, Giva
Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Bace - American Indian. 11. Marital Status Black, Whita, atc. hours after 1 □ Nevar Marriad 2 □ Married Maryland 21215-0036 1 Yas 2 No Specify: Specify: White by 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) 2 within Naval Ordnance Collega (1-4or 5+) Elementery/Secondary (0-12) Laboratory Accounting Clerk Hed a 18. Mothar's Nama (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Be should be and Mental Is merked 0 Powhatan Smith Buckley Katherine Duncan Shackelford 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 1 1 and 2 st 4 Health at 1 Hern 27 h Beverly Covell Kinsley / Daughter 1000 Stagecoach Road, Southeast, Albuquerque, NM

20a. Mathod of Disposition

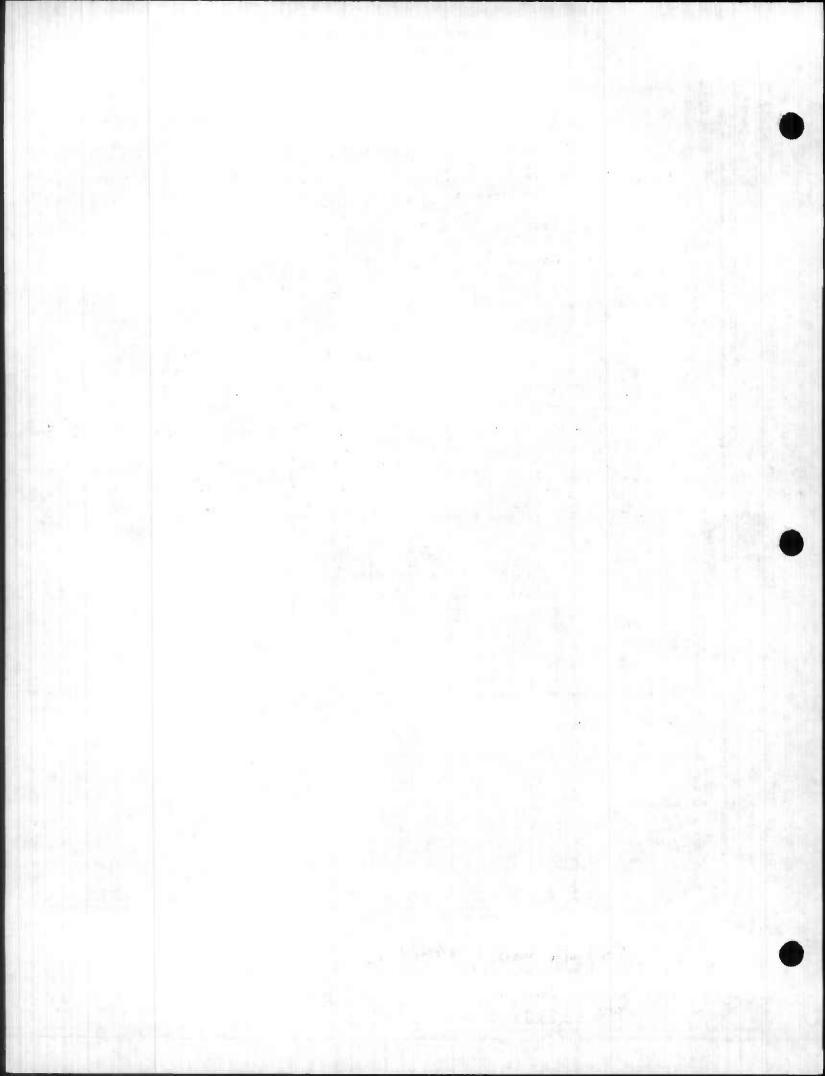
20b. Place of Disposition (Nama of cematary, cramatory or other place)

20c. Location - City of Town, State Saltimore. Pages nent of h permit. Pages Department of Important: If It 1 ☐ Burial 2 ACramation 3 ☐ Ramoval from State 4 Donation 5 Other (Specify) Metropolitan Crematory 12/29/00 Alexandria, VA 21. Signatura of Funaral Sarvice Licensaa 22. Name and Addrass of Facility Francis J. Collins Funeral Home, Inc. Sparmes 500 University Blvd., W, Silver Spring, MD 20901 Approximata Intervel Between Onset and Death 23a. Part 1 Entar tha disaasa, or complications that eaused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock or heart failure. List only one cause on each time. **Physician** /Medical Immediata Causa (Final disaesa or condition rasulting in daath) a Cardiac Arrythmia Examiner Dua to (or as a consaquanca of): Examiner Atrial Fibrillation been signed by the attending physician and should be detached for use as the burial-transit death certificate be executed Sequentially list conditions, if any, leeding to immadiata causa. Entar Undarlying Cause (Diseese or Injury Dua to (or as a consequence of): Box 68760. Physician/Medical that initiated evants rasulting in death) Lest Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? o the 1 | Yes 2 | No 3 | Probably 4 | Unknown ٩ that Cardiovascular Accident Records, þ requires 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of causa of death? The law page 2 s has 1 ☐ Yas 2 No 1 ☐ Yas 2 No this certificata of Vital Physician: Be funeral director, 25. Wes cese referred to medice! 26. Placa of Death (Check only one) axaminar Hospital: 1 ☑ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) 2 1 Yas 2 No 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Attending 1 XNetural 5 Pending invastigetion 1 ☐ Yas 2 ☐ No death. apital or Attendi tours after death. weral Director: A 2 Accidant 28f. Location (Street and Number or Flural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 3 Suicida 6 Could not be 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 10 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and mannar stated. Medical 29a. Certifier 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Dete signed (Month, Day, Year) AHENDINA String 6 D42580 MD December 26, 2000 30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print) MD 5632 Annapolis Road #13. Bladensburg, MD 20710 PsAujza, 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State DEC 28

Registrar **DHMH 16 Rev 6/95** 

2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** 23, 2000 December 12:45am Levitt Lawrence /Medical 4a Facility Nama (ff not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) NOV . 22, 1947 6. Sex 1 M M 2 F If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (fn yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Days Months Min. Hours Country) Maryland 53 Yrs. 230-66-7436 Director Usual Rasidence of Deceden with the Maryland 10d. fnside City Limits 10a. Stata 10b. County 10c. City. Town or Location so filed within 72 hours after death with the Marylan other than "... ratural", or forms 23s or 28s-1 shown over, the leads of the mast be notified as vivent, the leads of the mast be notified as Gaithersburg 1 Yas 2 No Maryland Montgomery Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20886 United States 18922 Montgomery Village Ave Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ②No if Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 1 Nevar Married 2N Married Specify: White 1 Yas 2 No Specify: à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) College (1-4or 5+) Elementery/Secondary (0-12) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If Isan 27 is marked other th any Injury or other treumatic svent, the page. Salesman Retail Sales 18. Mothar's Nama (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Be Geraldine Blumburg Ben Levitt 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, State, Zip Code) 18922 Montgomery Village Ave, Gaithersburg, MD 20886 Kay Levitt / Wife Baltimore. 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata National Crematory 12/26/00 Falls Church, VA 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Danzansky Goldberg Memorial Chapel, Inc 1170 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one ceuse on each line. Approximata Interval Between Onset and Deeth **Physician** Immediate Causa (Finat disaase or condition resulting in deeth) /Medical Respiratory Failure Examiner Dua to (or as a consequence of): Physician/Medical Examiner Adult Respiratory Distress Syndrome (ARDS) 5 Days the strending physician and hed for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disease or injury that initiated evants Dua to (or as a consequence ot): 3 Weeks Pneumonia Box 68760 Dua to (or as a consequance of): rasulting in death) Last Liver Disease, Hepatitis C 5 Years Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. has been signed by t ge 2 should be detact 1 Yea 2 No 3 Probably 4 M Unknown Ehlers-Danlos Syndrome Records, by 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy page urs after death. eral Director: After this certificata I filled in by the funeral director, pag 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attanding Physician: 25. Was casa rafarrad to medicel Be 26. Piece of Death (Check only one) Hospital: 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 7 1 Yas 2 No 28a. Dete of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. injury at Work? 28d. Dascribe how injury occurred Certification: 5 Pending invastigation 1 Neturat 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 6 Coutd not be 28a. Place of Injury - At homa, farm, straal, factory, office building, atc. (Specify) 4 | Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and mannar stated. edicai 29a. Certifier 29b. Signature and title of 29c. Licansa number 29d. Data signed (Month, Day, Year) D21977 December 23, 2000

State Registrar 31. Data filed (Month, Day, Year)
DEC 2 7 2000

Robert L. Rosenberg,

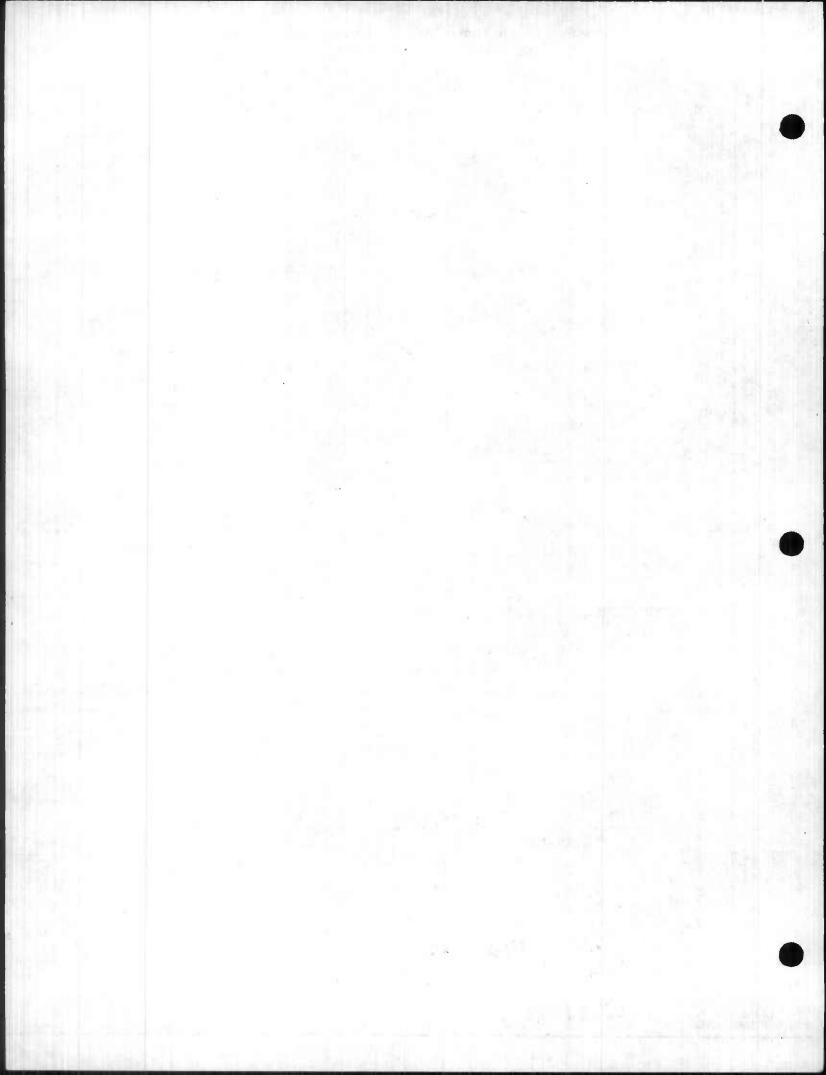
30. Name and address of cerson who complated ceusa of daath (Item 23a) (Type, Print)

MD

32. Begistrar's Signatura

1. Sparks

2730 University Blvd West #310, Wheaton, MD 20902



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of the Edith Month Mary McKinney

If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min.

**Physician** /Medical Examiner

4a. Facility Name (If not institution, give straet and number) Westminster Nursing & Rehabilitative Ctr.

5. Social Security Number

7. Age (In yrs. last birthday)

December 4b. City, Town, or Location of Death

8. Date of Birth (Month, Day, Year)

Westminster

22, 2000 2025 4c. County of Death

Kentucky

Birthplece (State or Foreign Country)

10d, Inside City Limits

Approximete Interval Between Onset and Deeth

minutes

3 years

3 years

3 Probably 4 Unknown

24b. Were eutopsy findings available prior to

completion of cause of death?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 62

Mt. Airy, MD 21771

1 Yes 2 No

Carroll County

**Funeral** 

Director the Maryland death

itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at filed within 72 hours after Hygiene. 2 should be fa pemit. Pagas 1 and 2 st Department of Haaith and Important: If itam 27 is m eny injury or other traum

Baltimore, Maryland 21215-0020

Box 68760

P.0

Division of Vital Records.

Physician /Medical Examiner

Examiner physician and the burial-transit certificata be axecu as l usa 0 tha datached signed by 2 Completed peen paga 2 certificata has Be To this funaral i or Attending Pt aftar daath. i Director: Aftar th Certification: tha To the Hospital of within 24 hours all To the Funeral D

1□M 2ਊF 315-36-5797 80 Nov 7, 1920 Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County Directo Maryland Carroll County Westminster 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1234 Washington Road 21157 United States Funeral 14. Race - American Indian, Bieck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify: white p 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) factory worker rubber manufacture 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) 8 John Thomas Marler Lulu Mae Wallen 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine Dayhoff / daughter 515 Clear Ridge Union Bridge, Maryland 21791 20b. Plece of Disposition (Name of cametery, cremetory or other plece) Dec 26 20e. Method of Disposition 20c. Location - City or Town, State 1 XBuriel 2 ☐ Cremetion 3 ☐ Removal from State Mt. Pleasant Cemetery Taneytown, Maryland 4 □ Donetion 5 □ Other (Specify) 2000 22. Name and Address of Facility Skiles Funeral Home M01072 136 East Baltimore Street un 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Final diseese or condition resulting in deeth) cardiac failure Due to (or as a consequence of) hypertension Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or es a consequenca of): Cardiac disease Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No anemia by 24e. Wes an autopsy performed? No No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 200 No 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Registrar

Medicai

completaly

Ernesto M. Mendoza, Jr., M.D. 31. Dete filed (Month, Dey, Year) DEC 2 6 2000

29b. Signature and title of cartifier

4 | Homicide

(Check only one)

29a. Certifier

32. Registrer's Signature

30. Name end address of person who completed cause of down (llum 23a) (Type, Print)

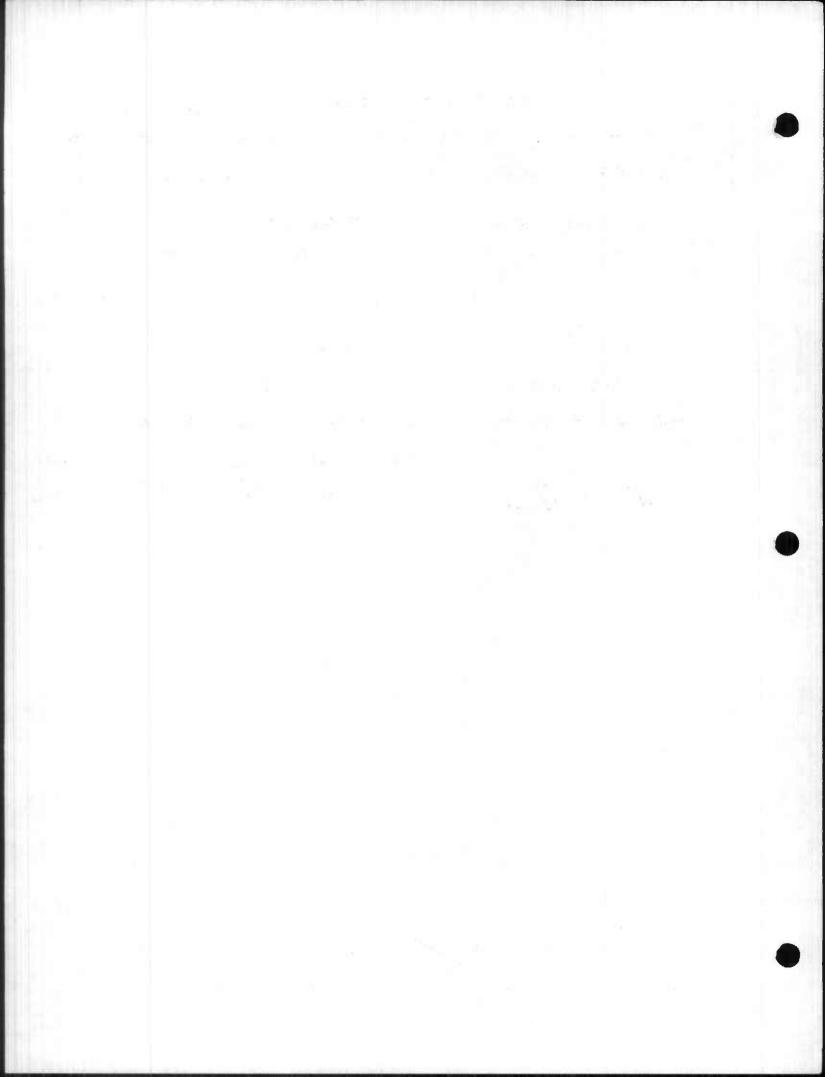
1001 Twin Arch Road

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner as steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and pleca, and due to the cause(s) end menner steted.

29c. License number

00050763



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 4283

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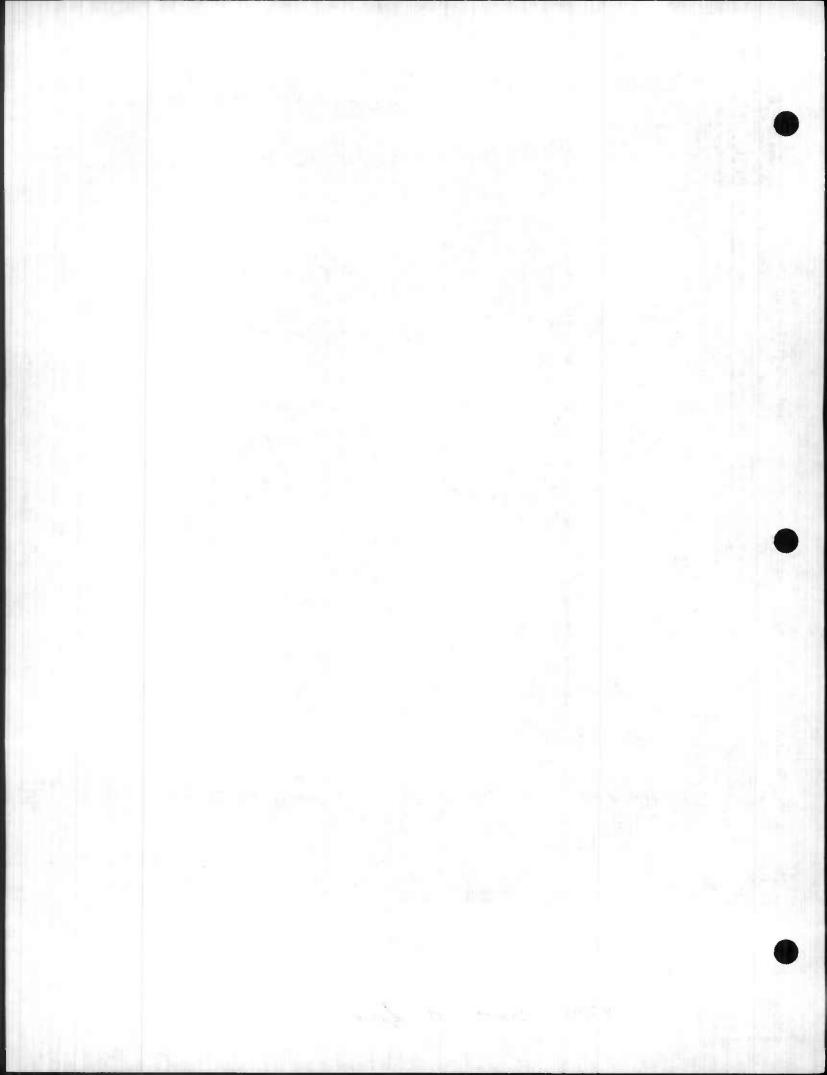
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Amended # 18, DRS Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 4 2 8 4 0

					Cei	Titica	te of	Death			Reg. No.	,	
Physiciar /Medica	P. 13. 7/	MCF	ARLA			1	2. Date of De	$R 2^{4y}$ , $2$	2000	3. Time of Death 5:00 a.m			
Examine	4e Facility Name (If not 103 ORMA)		FROSTE			OSTBU	BURG ALL			f Death LEGANY			
Funeral Director	5. Social Security Number 215-20-588	7 1	ex GM 2□ F	lest birthdey) Yrs.	If Und Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Pa IANUARY	y, 2,1919	9. Birthp Coun MA	lace (State or Foreign	
and w	Usual Residence of Dec	. County		10c. Ci	ty, Town or Lo	cation	-					1	0d. Inside City Limits
death with the Maryland	MARYLAND  10e. Street and Number	FROS	-	G ip Code				10g. Citizen of \	Whet Coun	1 □Yes 2 □ No			
3a or	103 ORMA			21.	532			U.S.					
9 2 2	11. Marital Status  1 Never Merried	11. Marital Status  12. Was Decedent Ever in U Armed Forces?  1 Never Merried 2 Married 1 Xes 2 No					edent of I ecify Cub 2 No	Hispanic Ori ean, Mexican Specity:		ecify Yes or No Rican, etc.)	14. Rec Blee	e - Americ ck, White,	etc.
hour hour	3 Widowed 4	Decedent's Ed		Dates: W.W.	1	fant's Lie	ual Occur	nation			16b. Kind of B		ITE
1 21215-UUZ led within 72 hours s bygiene. wr than "natural", o nt, the Medical Exer	(Specify or Elementary/Secondary	nly highest gra	ide completed	(1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of wife. DO NOT use retired)  OWNER / OPERATOR				ing	CAND			
Maryland 21215-0020 to 2 should be filed within 72 hours af th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Exert To Be Completed by	IIPTON DA		M		18. Mother's Name							NNISON	
	19a. informant's Name/I EDGAR A.					-					or, City or Town, TRG, MAR		
or then roth	20a. Method of Disposition  1 Suriel 2 Cro 4 Donation 5	emation 3		State	Place of Dispo cemetery, crer STBURG	netory or	other ple		K DEC	Date 228,200	20c. Location -		wn, State MARYLAND
Demit. Pag Department Important: I any injury o	21. Signature of Funeral Service Licenses  22. Name end Address of Fecility  DURST FUNERAL HOME  57 FROST AVENUE FROSTBURG, MARYLAND										ME P	.A.	
Physician	23a Pan Enter the dis	sease, or com ure. List only	plications that one ceuse on	caused the dea each line.	th. Do not ent							1	Approximete Interval Between Onset end Death
/Medical	Immediate Ceuse (Finel disease or condition Myocardial infarction									30 min			
Luzziller	resulting in death)	resulting in death)  Due to (or as a consequence of):  Arteriosclerotic cardiovascular disease										8 years	
oerificate be executed ding physician and se as the bunial-transit	Cause (Disease or injury that initiated events Due to (or as a consequence of):												
death cer e attendin ed for usa	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute										ntribute to	the cause of death?	
									10	1 Yee 2 No 3 Probably 4 Unknow			
need peen shoul				113	48			Fi			an autopsy ormed?	av	ere eutopsy findings allable prior to mptetion of cause death?
The la										10	Yes 25 No	10	Yes 25tNo
VICION: T		medical						26. Plece	e of Death	n (Check only	one)		
Physicien: This certific ral director,	1  Yes 2 No		1		ER/Outpatier		JOA				denca 6 □Ott		(v)
After	27. Manner of Death 1 Natural 5 2 Accident 3 Suicide 6	Pending investigation						jury at ork? □ Yes 2 □ No 28f. Location (Street end Number or Rurel Route I					
To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completaly filled in by the		determined	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)							City or To	wn, Stete)		
To the Hospital or within 24 hours afta To the Funerel Dir completely filled in	29a. Certifier 1 (Check only 2 (Check only one)	Certifying Ph Medical Exan	niner: On the	e best of my kno basis of exemina nner steted.	owledge, deetl ation and/or in	occurre vestigation	d at the ton, in my	ime, date an opinion, dea	nd place, a ath occurr	and due to the red at the time,	cause(s) and m date end place,	anner es s and due to	tated. the ceuse(s)
To the within To the compl		of certifier				2	9c. Licen	se number			29d. Date signe	d (Month,	Dey, Year)
7	Donne and address of person who completed cause of death (Item 23a) (Type, Print)  DECEMBER 24								4, 2000				
nes		NALD M					CUM	BERT A	ND.MA	ARYLAND	21502		
State Registrar	31. Date filed (Month, Da	2000	532.	Registrar's Sign	ature	loa	Ka/		7. **				

Registrar

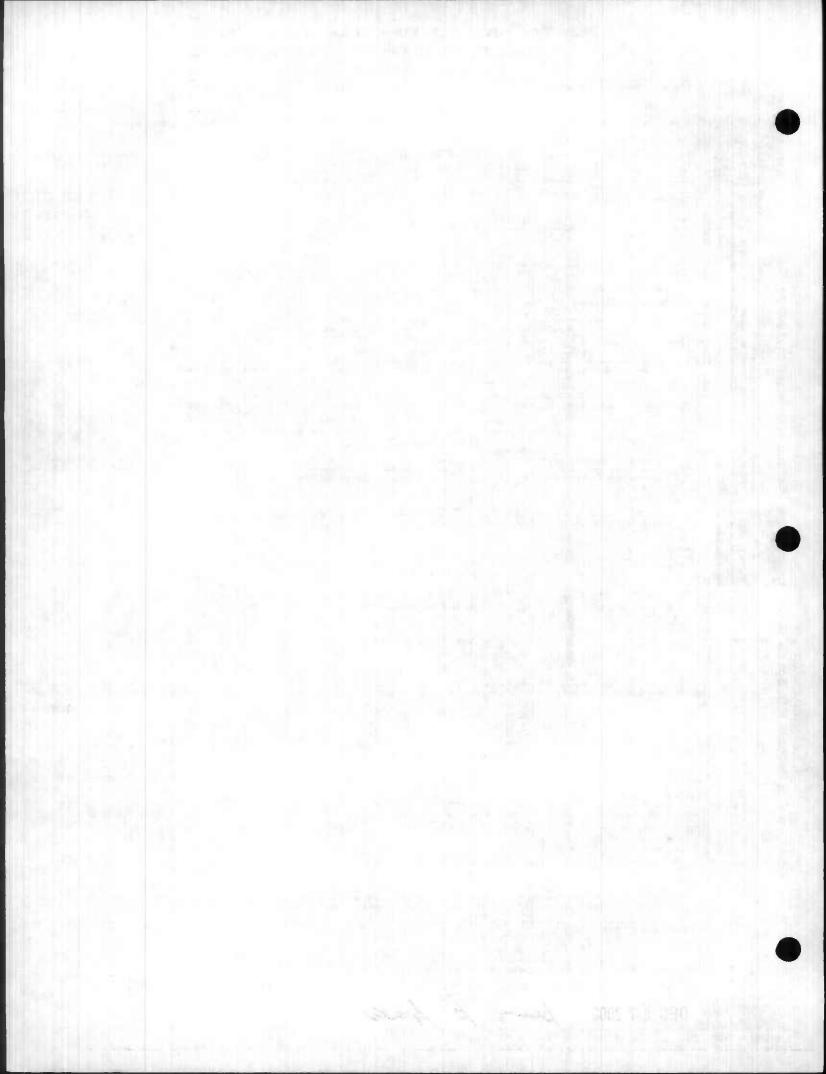


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State of Maryland / Department of Health and Mental Hygiene | 1291

			State of Marylan	Certifica				ig. No.	46	041		
		1. Decedent's Name (First, Middle, Last,	2. Date of Death	2. Date of Death			eath					
	Physician /Medical	Olive			R 25,20			,				
	Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or L		4c. County of				
		Memorial Hospit	cal			Cumberl				legany		
	Funeral Director	220-30-8522	7. Aga (In yrs.	Months	er 1 Year s Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, Dec 8,	<sup>Yaar)</sup> 908	9. Birthple Counti	MD	Foraign	
	eryland show dat	Usual Rasidence of Decedant  10a. Stata 10b. County 10c. City, Town or Location									Limits	
	Me M	MD Alle	gany	Cumber		d				1 □ <b>X</b> es 2	: 🗆 140	
	ther death with the Marylar r thems 23a or 28e-f show note must be notified at Funeral Director	10e. Street and Number 209 South Street	et	10f. Z	ip Code	21502	10	og. Citizan of W USA	hat Count	ry?		
020	sf. or its Examine by Fur	11. Marital Status  1 Nevar Married 2 Married  3 Nidowed 4 Divorced	12. Was Decedant Ever in U Armed Forces? 1 ☐ Yas 2 ☐ Alio If Yas, Give Yaar or Datas:	,S. 13. Was Deci If Yes, sp 1 ☐ Yas		lispanic Origin? (Sj an, Mexican, Puart Specify:	pecify Yas or No- o Rican, atc.)		- Americe c, White, a whi	tc.		
15-0	n 72 ha natur edical	15. Decedant's Edu (Specify only highast grad	cation a completed)	16a. Decedent's Us (Giva kind of w	ual Occup vork dona	pation during most of world)	king	6b. Kind of Bus	sinass/Indu	ustry		
212	of within	Elamantary/Secondary (0-12)	College (1-4or 5+)	Homemake		o)		Own Ho	ome			
land	Auto be filed within 72 has Mental Hygiene. That other than "natural site event, the Medical. To Be Completed	17. Fathar's Nama (First, Middla, Last)  David Bradley				18. Mother's Nam Hannah	na (First, Middla, M M (H	faidan Sumama awkins				
522 Maryland 21215-0020	nd 2 should be the set Menta 27 is marked or traumatic a To E	19a. Informant's Name/Ralationship (Ty Audrey J. Roby	pe, Print)	19b. Mailing Address 542 Win	ss (Street ifre	and Number or Ru d Road;	ral Route Number, Cumberl	City or Town, S and MD	Stata, Zip (	Coda) 502		
220-30-8522 Baltimore, Ma	Pages 1 a ent of Has th: If Item y or othe	20a Method of Disposition  1	emovat from Stata	Place of Disposition (National August 1997) or Camatary, cramatory or	othar pla		12/28	20c. Location - (				
Baltin Baltin permit. P Departme important any halun anos	Departit. Departm Importar any Injur	4 Donation 5 Other (Specify)  Hillcrest Memorial Par2000 Cumberland, MD  21. Signatura of Funeral Sarvice Licenses  SCarpellard, MD 21502										
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat					st,		Approximata Intarvai Betwe	0.00	
0	Physician /Medical Examiner	immediate Cause (Final disease or condition	Sepsis							Onsat and De	eath	
	SECULIARES	rasulting in death)  a. Due to (or as a consequence of):										
	executed in and itel-trensit	Sequentially list conditions.  Dua to (or as a consequence of):								10 years		
68760,	ficate be executed globysicien and as the buriel-trensit edical Examir											
E M. Box 6	E 0 6											
VE.	at the death cent d by the attendin eleched for use Physician/N	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying	cause giv	ven in Part I.	23b. Did to	bacco uae con	tributa to	the cause of	death?	
, P.O. E	igned by the be deteched by Phy.	1 □ Yes 2 □ No								ably 4 LU	nknown	
MORTON, Records,	w requir s been s abould						24a. Was an	n autopsy ned?	ava	ra autopsy find ilable prior to aplation of cau leath?		
	The law are hes page 2						1 ☐ Ya	s 2 No	10	Yes 2 N	lo	
ita i	entifica ector.	25. Was cesa rafarred to medicel axaminar?				26. Placa of Dea	ath (Chack only on	а)				
7	Physician: The la rthis certificate hes aral director, page 2 n: To Be Comp	1 ☐ Yas 2 ☑ No		ER/Outpatient 3 0		4 LI Nursing H	oma 5 🗆 Reside			)		
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	in 24 hour he Funer pletely fill:	29a. Cartifiar (Check only one) 1 Cartifying Physics Cartifying Physic	lician: To the best of my knower: On the basis of examine and manner stated.	wiedga, daath occurre tion and/or invastigatio	d at the til	ma, data and place opinion, daath occu	, and dua to the ca rred at the time, de	usa(s) and ma ata and place, a	nnar as ste and dua to	tha causa(s)		
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	mel	30. Nama and address of person who co SUNIL K. GUPTA, MI			101.	CUMBERL	AND, MD	2150	)2			
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DHMH 16 Rev 6/95

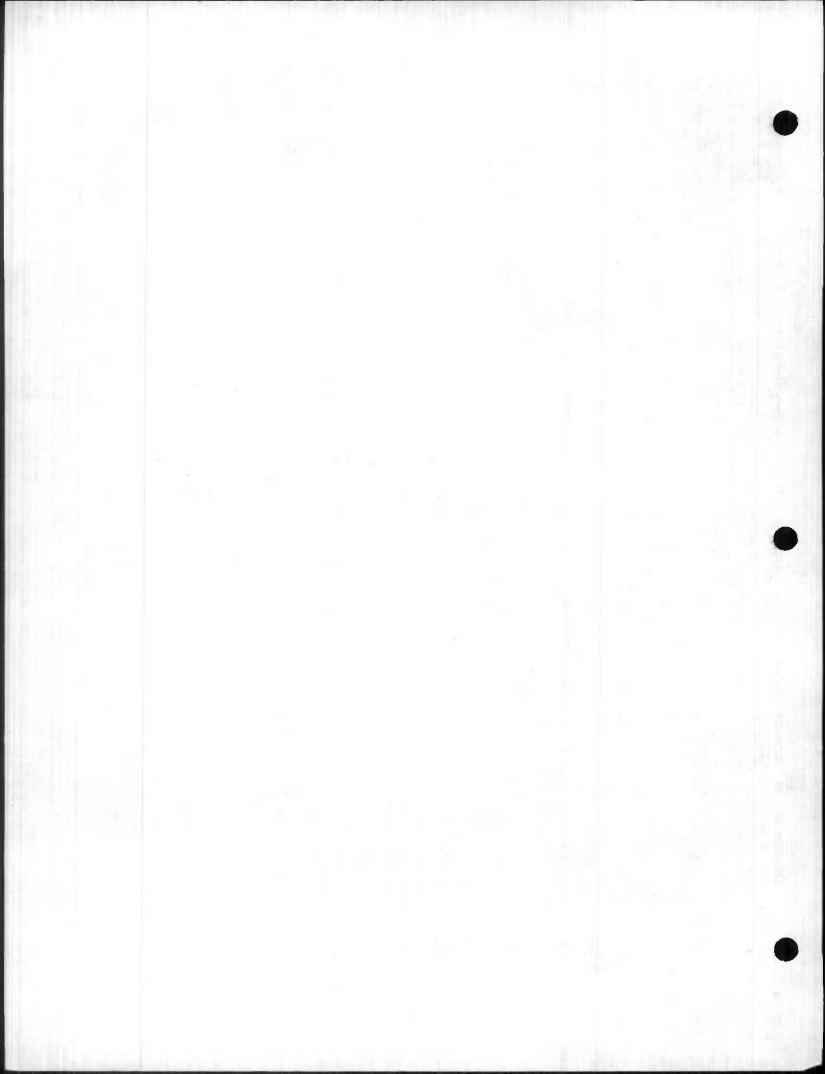


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Evelyn K. Muller 21, 2000 2:52 PM December /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□ M 2K F 79 June 5, Director 579-18-2422 Virginia Usual Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location r than "natural", or Itama 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 21 No Director Maryland | Montgomery Silver Spring 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Valley Brook Dr. 20904 Funerai United States death 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 20 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: Specity: White þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Pages 1 and 2 should be filed withir nent of Health end Mentel Hygiere. Int: If Item 27 is marked other than Jry or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James F. Kidwell Elsie E. Wright 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry G. Muller, Jr. 200 Valley Brook Dr., Silver Spring, MD, 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removel from State December **Department** 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 23, 2000 Bethesda, Maryland 21. Signature of Fulleral Sarvice Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue MUU335 Rockville, Maryland 20850–2805 Rockville, Maryland 2085 23a. Part1. Enter that shock, or heart fi Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Coronary Artery Disease 5 Years disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner Abdominal Aneurysm 5 Years sicien and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequance of): physicien s the burial Box 68760, Physician/Medical Due to (or as a consequence of) 98 use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2♥ No 3 Probably 4 Unknown Vasculitis Records, þ 500 Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to End Stage Renal Failure completion of cause of death? pege 2 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director, Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☒ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending e Hospital or Attending n 24 hours after deeth. 1 Yes 2 No investigation 2 Accident 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, streat, factory, offica building, atc. (Specify) 3 4 Homicide filled in 1 Certifying Physician: To the best of my knowledga, daath occurred at the tima, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the To the To the F 29b. Signature and title certifier 29c. License number 29d. Data signed (Month, Day, Year) D21340 December 21, 2000 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Bass 3941 Ferrard Drive, Wheaton, Maryland, 20906 31. Dete filed (Month, Day, Year) 32. Degistrar's Signature State souks DEC 2 6 2000 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death **Physician** Edward Thomas Moxley, Ir. 7:37 p.m. 22, 2000 December /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Undar 24 Hrs. Hours Min. If Under 1 Yaer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Yaar) Birthplace (Stata or Foreign Country) **Funeral** 1√2 M 2□ F Days Months Yrs. 577-52-2787 Director Feb. 20, 1939 Washington, D.C Usual Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic ayant, the Medical Examinar must be notified at 1 ☐ Yas 2 ☐ No Director Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ŏ 238 apt. #214 United States Funeral 116 Lee Ave. 20912 should be filed within 72 hours efter death 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indien. Black, Whita, atc. 1♥ Yes 2 No If Yes, Giva Year or Datas: WWII 1 Never Merried 2 Married 6 Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b Kind of Business/Industry al Hygiene. Elemantery/Secondary (0-12) College (1-4or 5+) Southeast Recycling Co. Recycler 17. Father's Nema (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surname) Be and Mental F Thomas Moxley, Ruth Arnett Edward 19a. Informant's Name/Ralationship (Type, Print) 19b. Maiting Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Peges 1 and 2 sh Department of Health and Important: If item 27 Is m any Injury or other traum 116 Lee Ave., apt.# 214, Takoma Park, Md. 20912

20b. Place of Disposition (Nama of cematary, cramatory or other place)

Date 20c. Location - City or Town, Stata -Sister Mary C. Moxley
20a. Mathod of Disposition Saltimore, 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Othar (Specify) 12-30-00 Beltsville, Md. Chesapeake Crematory Inc. 21. Signeture of Funaral Sarvice Licensae 22. Nama and Addrass of Fecility Rapp Funeral and Cremation Services, Stephen D. Lohrmann P.A. Stephen D. Lonrmann r.A.

23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the model of the same around the factor production. Md. shock, or heart failure. List only one cause on each line. 209 policimete Interval Batwaan Onsat and Deeth Physician Immedieta Cause (Final disaasa or condition resulting in death) CARDIOPULMONEARY /Medical Examiner Dua to (or as a consequence of):

STAPHY LOCOCCAL SEPTICEMIA Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or Injury that Initiated avents rasuiting in death) Last The law requires that the death certificate be avecut the burial-tran EREBLOVASCULAR Box 68760. use as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the causa of death? 1 ☐ Yes 2 Probably 4 ☐ Unknown signed by of Vital Records, PV 8 24b. Wara autopsy findings aveilable prior to complation of causa of death? page 2 should Be Completed 24a. Wes en eutopsy performad? this certificate has 1 Yes 2 No 1 ☐ Yas 25 No or Attanding Physician: the funeral director, 25. Was casa rafarred to medical 26. Placa of Death (Check only one) Hospitel: 1 Ma Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 ☐ Yas 2 No Medical Certification: To 27. Menner of Death 28a. Data of Injury (Month, Dey Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how Injury occurred Division 1 Natural 5 Pending invastigation 1 Yas 2 No 2 Accidant after deeth 6 Could not be datamined 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours at To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at tha time, date end place, and dua to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted. 29a. Certifier completaly (Check only one)

State Registrar 29b. Signatura and this of certifian

31. Date filed (Month

32. Pegistrer's Signeture

MD

who completed causa of daath (Itam 23a) (Type, Print) HARROVER PARKWAY GREENBELI MARYLAND

29c. Licansa number

29d. Data signed (Month, Day, Year)

and the state of t THE PERSON NAMED IN COLUMN TO THE PE

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1	/Medical Examiner	4e Facility Nama (If not institution, give		11 (11)		4b. City, Town,		_				
	Examiner	COLLINGSWOOD	NURSING AND	REHAB.	CENTER	ROCKV	TIME	Mo	ONTGO	MERY		
	Funeral	5. Social Security Number 6. S	ex 7. Age (In )	yrs. lest birthday	1 1/17 1 / 17	If Undar 24						
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anda	athor po			. Only, FOWIT OF E								
2	or 28a-f show be notified at Director	MD. MONTGOM	ERY		10f. Zip Code	RSBURG		10a Citizan of V	What Count	ERY e (State or Foreign NESSEE Inside City Limits 1 Yas 2 No recause of death?  AVE. MD. 20737  Provinete terval Between neet and Death  Clay 4 Unknown  autopsy findings abla prior to detion of ceuse ath?  Fourte Number, ed. ee cause(s) y, Year)		
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101	ltems foer.ms	1 Never Married 2 Married	Armed Forces?	10.	If Yes, specify Cub	en, Mexicen, P	uarto Rican, etc.)	Bled				
336	by B	3 ☑ Widowed 4 ☐ Divorced	If Yes, Giva Year or Detes:		1 ☐ Yes 2 ☒ No	2. Dete of Death Month Deay Year 10:20 PM DEC, 26, 2000 10:20 PM  b. City, Town, or Location of Death PCC, 26, 2000 10:20 PM  b. City, Town, or Location of Death Acc. County of Death POTO PM  ROCKY ILLE MONTGOMERY  Windar 24 Hrs. 8. Data of Birth MAY 29, 1916 9. Birthplace (State or Foreign County) PMAY 29, 1916 10d. Inside City Limits 1 12 Yas 2 No  10g. Citizen of Whet Country?  10g. Citizen of Whet Country?  10g. Citizen of Whet Country?  10g. Citizen of Whet Country?  11g. Yas 2 No  10g. Citizen of Whet Country?  11g. Yas 2 No  26. Place of Death (Check only one)  11g. Yas 2 No  11g. Yas 2 No  26. Place of Death (Check only one)  11g. Yas 2 No  27. City or Town, Stete)						
21215-0036 d within 72 hours at	ted bet	15. Decedent's Ed	ucetion	16a. Dece	edent's Usuel Occup		16b. Kind of Bu	siness/Ind	ustry			
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	the state of the s	19e. Informant's Name/Relationship (7		r Rural Route Numb	er, City or Town,	Stete, Zip	Code)					
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_		W.W. Cha	mercis M	00091 C	HAMBERS F	UNERAL	HOMES, P. A	., RIVE	RDALE			
		shock, or heart failure. List only	one cause on each line.	death. Do not er	iter the moda of dyi	ng, such as cer	rdiac or raspiratory a	rrast,	1	Interval Between		
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pite	ours filled	29a. Certifier 1/2 Certifying Phy	valctan: To the best of my	knowledge, dee	th occurred at the ti	ime, date and p	elece, and due to the	cause(s) end me	enner as st	ated.		
5	n 24 hou he Funer pletely fil edical	(Check only 2 Medical Examone)	iner: On the basis of examend manner stated.	ninetion and/or li	nvestigation, in my	opinion, deeth	occurred et the time,	date and place,	and due to	the cause(s)		
Division To the Hospital or Attending	Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signe	d (Month, I	Day, Year)		
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		30. Nama and address of person who	completed ceuse of deeth	(Item 23a) (Type		puc 1	10 0.	200	1	0000		
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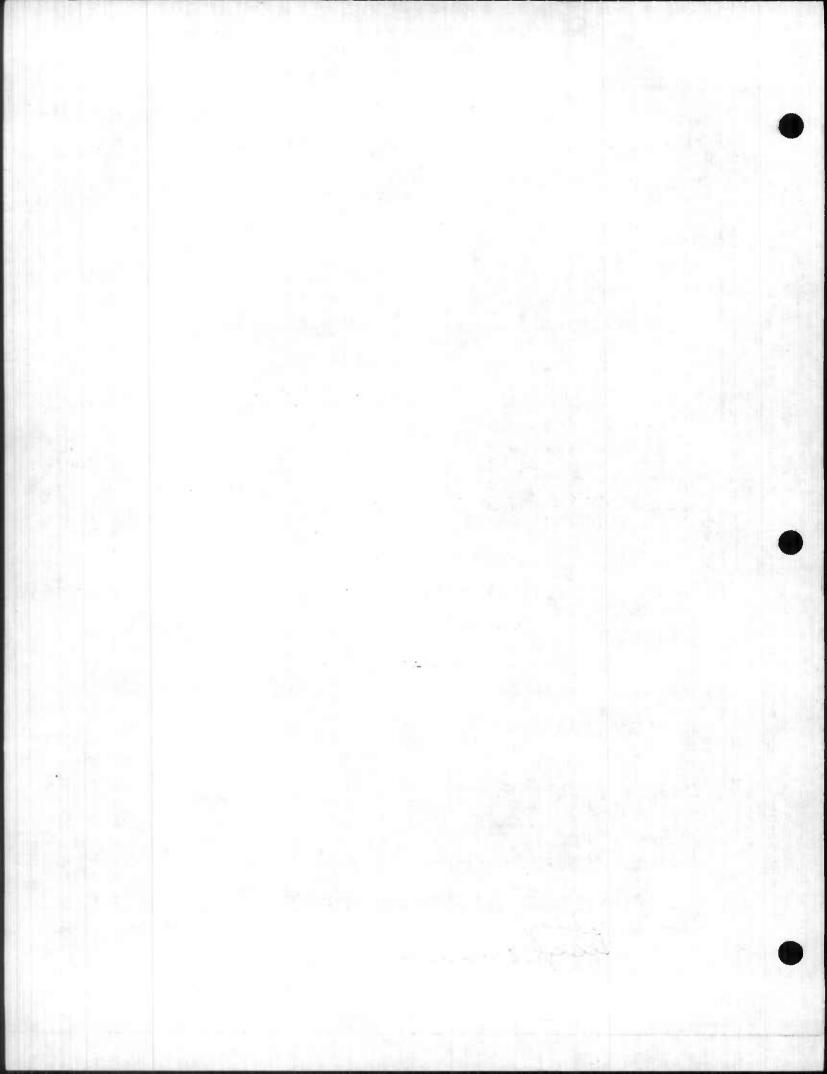
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death Dev Month Vear **Physician** Harry Montgomery J. December 21, 2000 6:45 pm /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Manor Care - Chevy Chase Chevy Chase Montgomery If Undar 24 Hrs. Hours Min. If Under 1 Year 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplaca (State or Foreign Country) 6. Sex 1 M 2 □ F **Funeral** Days Months 82 Yrs. Director Jan 13, 1918 577-18-6194 DC Usual Residence of Deceden with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f ahow r than "natural", or hama 23a or 28a-f ahov the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 5124 Newport Avenue 20816 death 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indien. 11. Maritel Stetus Bleck, White, etc. 72 hours after 1 ☐ Nevar Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. should be filed within Elementery/Secondery (0-12) College (1-4or 5+) 12 Treasurer Prosthetics other treumetic event, 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middle, Last) Be h and Mantal h 2 Francis Montgomery Elizabeth Judge 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 ( of Health of 5142 Newport Avenue, Bethesda, MD 20816 Mary Ann Egan / Daughter other Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stata 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If it any injury or o W Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) Gate of Heaven Cemetery 12/26/00 Silver Spring, MD 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one causa on each line. Approximete Intervel Between Onset and Death **Physician** Immediete Cause (Finel diseese or condition resulting in death) /Medical a Aspiration Pneumonia 3 days Examiner Due to (or es a consequenca of): Examiner Cerebrovascular Accident vears The law requires that the death certificate be executed ed by the attending physician and detached for usa as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Dementia years Physician/Medical Due to (or es e consequenca of): USB BS d Seizure Disorder years P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Hypertension Records, p 24b. Were autopsy tindings eveilabla prior to completion of cause of death? page 2 should Completed 24e. Wes en eutopsy performed? D860 certificata has 1 Yes 2 No 1 Yas 2 No of Vital Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To After this 27. Menner of Deeth funeral 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending invastigetion Division or Attanding a blrector: Aft of in by the fur 1 Yas 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital o within 24 hours of To the Funeral Di Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated. edical 29e. Certifier completely (Check only one) 29b. Signature and yilg of 29c. License number 29d. Date signed (Month, Day, Year) telo 10 D 32033 December 22, 2000 mun 30. Nema end address of person who completed cause of death (Item 23a) (Typa, Print) MD 5454 Wisconsin Ave., Peter G Hamm, Chevy Chase, MD 31. Dete filed (Month, Day, Year) 32. Registrar's Signetura State ooks DEC 26 2000 Procured Registrar

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**ORIGINAL** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DEC. **Physician** 27° 2000 MONTENEGRO MARIA LUCILA 2135 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY CROVE ADVENTIST HOSPITAL 5. Social Security Number 6. Sex 7. Age (In vrs. le MONTGOMERY ROCKVILLE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV . 1, 1903 if Under 1 Year 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country)
Ecuador **Funeral** Days 1 M 20 F Months 97 044-60-8815 Director Usuai Residenca of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner name be notified at 10d. Inside City Limits Yes 2 No Director MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11600 20876 U.S.A. Oueen Nicole Terrace Funeral death 12. Was Decedent Ever in U,S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Raca - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene Important: If Item 27 Is marked other than I'm any injury or other traumatic auch. Public Schools of Elamentary/Secondary (0-12) College (1-4or 5+) Ecuador School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumeme) Be Victor L. Montenegro Zoila Cisneros 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Coda) 20876 19a. Informant's Name/Relationship (Type, Print) Maria M. Calderon (Daughter) 11600 Queen Nicole Ter., Germantown, MD 20b. Placa of Disposition (Neme of cemetary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan F/Serv.12/29/00 Alexandria, VA 21, Signature of Funeral Service Liptobee 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical SEPTICENIA Immediata Cause (Final disease or condition resulting in death) ~ I WEEK Examiner Due to (or as a consequance of): RISPIRMORY sician and buriel-transit Sequantially list conditions, if any, leading to Immadiate cause. Enter Undarlying Causa (Disaase or Injury that initiated events resulting in death) Last physician a Box 68760 Physician/Medical Due to (or as a consequenca of): 80 0 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown signed Division of Vital Records, by Pe 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No certificate 25. Was casa raferred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 2 L 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred he Hospital or Attending P n 24 hours effer deeth. Certification: 28c. Injury at Work? After 1. Natural 5 Pending Investigation 2 Accidant 1 Yes 2 No 3 Suicide 6 Could not be datarmined 28f. Location (Streat end Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurrad at tha time, date and placa, and due to the cause(s) and mannar as statad. Medical 29a, Certifian (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the causa(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar ISABELLA

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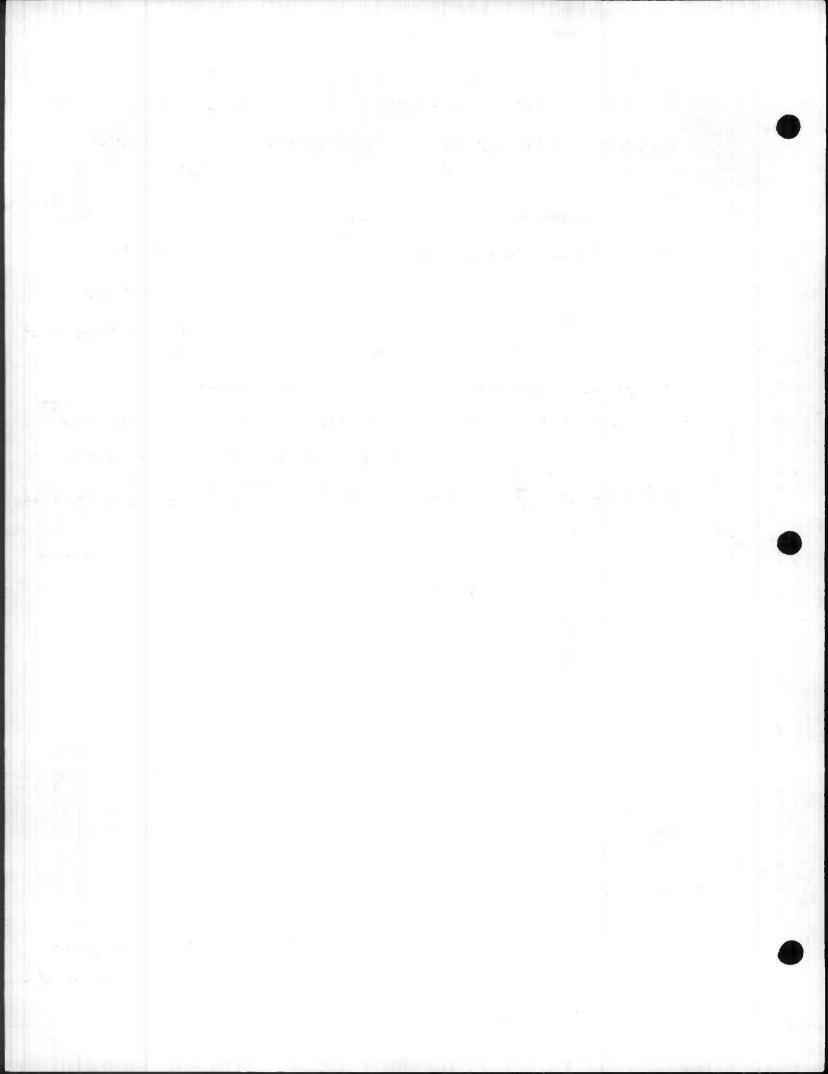
31. Date filed (Month, Day, Year) 32. Begistrar's Signature DEC 2 9 2000

3418

OLMOWOOD COURT #111

30. Name and address of parson who completed causa of death (Itam 23a) (Type, Print) MARTIRE MO

DECEMBER 28/2000



Please Type or Print in Biack indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1/3/2001, GF, Montq.Co. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** DECEMBER 25, 2000 5:00 PM LOUISE MINNER /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Linder 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 M 25 F FEB 28, 1911 Director NEW YORK 085-07-1949 Usual Residence of Decedent tha Maryland 10a. State 10c. City, Town or Location 10d. tnside City Limits 10b. County d other than "natural", or hams 23a or 28a-f ahow avent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐No MARYLAND MONTGOMERY ROCKVILLE Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 USA 9701 VEIRS DRIVE Funeral death 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U.S. Armed Forces? 11. Maritel Status Bleck, White, etc. e filed within 72 hours after all Hyglena. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE Specify: þ 3 ₩ Widowed 4 Divorced Year or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY PRIVATE 4 permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic avent phics. 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumeme) Be EDNA MAPES GEORGE VanHOUTEN 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) 24701 OLD HUNDRED ROAD, COMUS, MARYLAND ALFRED MINNER/SON 12 Date 29 | 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 2000-1 NATIONAL F.H. CREMATORY FALLS CHURCH, VIRGINIA 21. Signature of Funeral Septem Licensee 22. Name and Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Approximete Interval Between Onset end Deeth 23 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** tmmediete Cause (Finel disease or condition resulting in deeth) /Medical • GASTROINTESTINAL HEMORRHAGE Examiner Due to (or es a consequence of): Examiner COUMADIN THERAPY iew requires that the death certificate be asscuted Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical Due to for es e consequence of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION by Division of Vital Records, 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? certificata has been si irector, page 2 should eted Compl page The 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No : After this certifica e funaral director, p or Attanding Physician: 25. Was cese referred to medicel Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 🛱 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Dete of tnjury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred tniury 5 Pending death. 1 Yes 2 No investigation 2 Accident Diractor: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 2 4 Homicide To the Hospital or A Within 24 hours after To the Funeral Dirac completely filled in b 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier edical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of certifier

State Registrar

DEC 29 2000

31. Date filed (Month, Dey, Year)

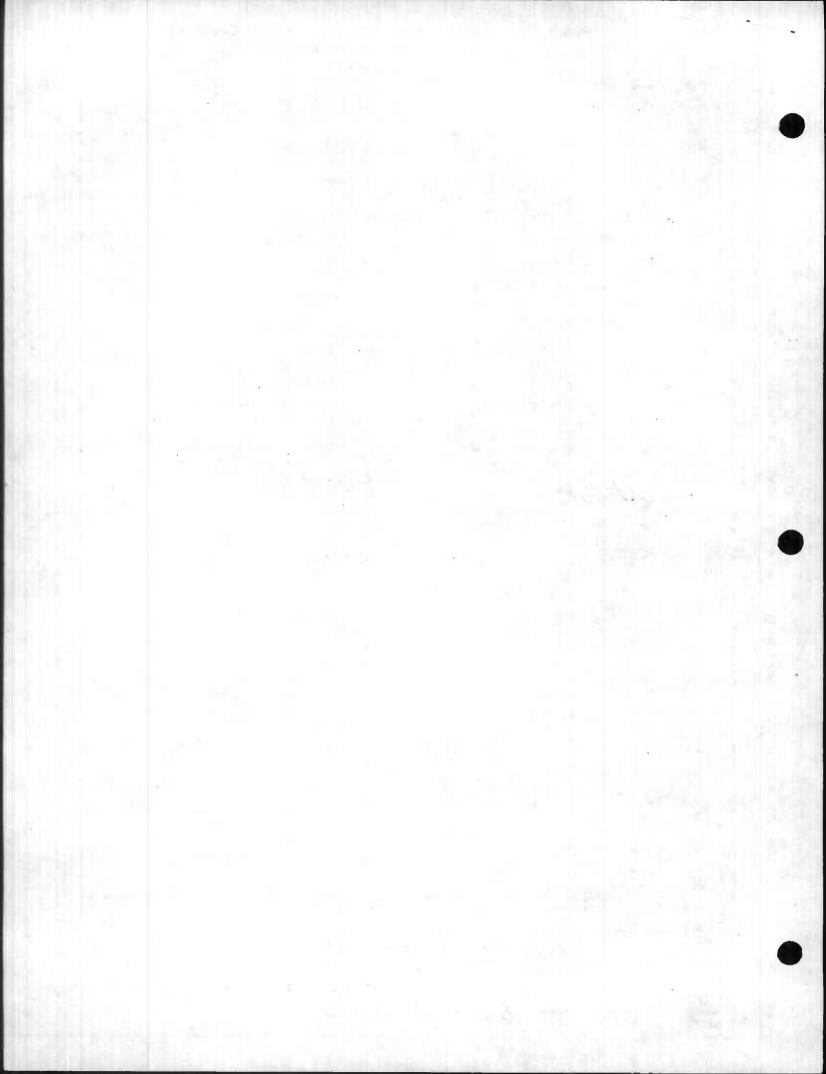
KATHARINE R. LILLIE,

30. Name and address of person who completed ceuse of deeth (ttem 23a) (Type, Print)

MD 11140 ROCKVILLE PIKE, PMB 348, ROCKVILLE, MD 20852 32. Registrer's Signeture

D 53244

DECEMBER 25, 2000



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Day 19 2000 3:36 PM Messolonghites Dec. Louis 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sandy Spring Montgomery Sharon Nursing Home If Under 1 Yeer If Under 24 Hrs. 8. Data of Birth Months Deys Hours Min. (Month, Dey, Year) 5. Sociel Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) Deys 1X M 2□ F Yrs 95 June 26, 1905 Ohio 174-01-1157 Usuel Residence of Decedent 10a. Stata 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yas 2 ☑ No Sandy Spring Maryland | Montgomery 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 20860 United States 18201 Marden Lane 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Yaer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, 11. Meritel Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ₩ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Editor/King Features Elementery/Secondary (0-12) College (1-4or 5+) Syndicate 12 Journalist 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) R. Smith Messolonghites Cora Constatine Nicholas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 7 Woodland Road, P.O. Box 193, Brookside, NJ 07926 Sarah Flaherty/Daughter 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stata Dec. 23 1 Burie! 2 Cremetion 3 Ramovel from State 4 Donation 5 Other (Specify) Beltsville, Chesapeake Crematory Inc. 2000 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Rapp Funeral & Cremation Serv. Stephen D. Lohrmann, 933 Silver Spring, MD 20910 Gist Ave. 23a. Pail 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset end Deeth Immediate Cause (Final MYOCARDIAL INFARCTION HOURS disease or condition resulting in deeth) Due to (or as e consequence of) ATHEROSCUEROTIL HEART DISEASE Due to (or es e consequence of): Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 48 Unknown 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) 1 Yes 22No 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner physician and s the burial-transit that the death certificate be axecuted

attending pl

signed by the a d be detsched f

is certificata has b director, page 2 s

be or Attending Physician: The state death.

It Director: After this certificate ed in by the funeral director, ps

• Hospital of 24 hours all etaly filled in

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Examiner

Physician/Medical

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Certification:

Medical

**Physician** 

/Medical

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Director

th and Montal Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumstic event, or Modical Examinat must be notified at

. Pages 1 and 2 should be fill mant of Health and Mental Hant: If item 27 is marked off lury or other traumatic even

permit. Page Department of Important: If any Injury or once.

the Maryland

with

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

VASCULAR DEMENTIA

Other: 48 Nursing Home 5 Residence 6 Other (Specify) 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

28e. Plece of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

🗺 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signature end title of certifier

27. Menner of Deeth

1. Naturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29c. License number

29d. Date signed (Month, Dey, Year) DECEMBER 20, 2000

- ATTENDING PHYSICIAN

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CRACE BROOKEHTHMAN, M.D. 18100 SLACESCHOOL ROAD SANDY SPRING MARYLAND 20860 31. Date filed (Month, Day, Year)

State Registrar

DEC 2 6 2000

5 Pending investigation

6 Could not be determined

32. Registrar's Signeture Cours

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State of Maryland / Department of Health and Mental Hygiene Amend #13,12/28/2000, BMW, Montg. Co. Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth 250 Month Dev Year **Physician** Phoebe Merson - 2000 PM 19 21 /Medical to Focility Name (If not institution, give street and number)
Forest Gen Skilled Pursing and Rehabilitation Center Silver Spring 4b. City, Town, or Location of Deeth 4c. County of Deeth H Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) Montgomery 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 M 2 KF 90 Yrs 579-09-8062 Director Mary land Usual Residence of Decede Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumetic avent, the Medical Exercityer must be notified at Silver Spring Maryland Montgomery 1 Yes 2 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 United States 2700 Barker Street death v Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 11 Merital Status Bleck, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 You 2 XNo Specify: White by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Clerk retail 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Davis Long William Tnez. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 13200 Galvez Street Wheaton, Maryland 20906 Dodie Geiser - Granddaughter Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) 12/23/2000 Burtonsville, Maryland Union Cemetery 21. Signature of Funerel Service Licenses Donald V. Bordwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Lday urbsepsy Examiner Due to (or es a consequence of) Examiner physician and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequenca of): 88 attending USa ō signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown λq The law requires should ! 24b. Were eutopsy findings evalleble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? is certificate has director, page 2 a page 1 Yes 2 No 1 □ Yes 2 □ No Division of Vital Physician: Be 25. Wes case referred to medical 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Lo Aftar this funerel dir 28c. Injury et Work? To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After it completely filled in by the funera 27. Menner of Beath 28d. Describe how injury occurred Certification: 5 Pending investigation 1 DNaturel 1 Tyes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide edical Tell Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 2 person who completed cause of deeth (Item 23e) (Type, Print) DEC 28 31. Dete filed (Month, 32. Registrer's Signature State Osnera Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

is in the state of

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Amend #2,12/29/2000, BMW, Montg. Co. 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death Month Dey25 Year **Physician** December  $\frac{24}{}$ , 2000 12:10 am Bridget Mary McCov /Medical 4b. City, Town, or Location of Deeth 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery Birthplace (State or Foreign Country) 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number **Funeral** 1□M 2\ F Months Deys Hours Min Yrs. 88 Director 1912 Ireland 577-44-7173 Usual Rasidence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show th end Mental Hygiene.
7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Examinar I must be notified. 1 Yes 2 No Directo Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4811 Russell Avenue USA Funeral 20782 12. Wes Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ₺ No If Yas, Giva Year or Detas: Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - American Indien. Black, Whita, atc. filed within 72 hours after 1 □ Never Married 2 □ Married Maryland 21215-0020 1 Yas 2 No Specify: Specify: White g 3X Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker 8 Own Home 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) permit. Pages 1 and 2 should be file Department of Heelth and Mental th Important: if item 27 is marked oth any injury or other traumatic event page. Be Thomas Cahill Alice Wall 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. tnforment's Neme/Reletionship (Type, Print) Eileen Cullen / Niece 2594 Collier Road, Manasquan, NJ 08736 Baitimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20e. Mathod of Disposition Burial 2 Cramation 3 Removal from Stata Gate of Heaven Cemetery 12/29/00 Silver Spring, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility
Francis J. Collins Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licenses 500 University Blvd., W, Silver Spring, 23a. Parti Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. MD 20901 Approximeta tntarval Batween Onset and Death Physician Immediata Causa (Final disaasa or condition rasulting in death) /Medical SEPSIS ~ 10 dy **Examiner** Dua to (or as a consequence of): Examiner CERBBRUVASCULAR ACCLOENS The law requires that the deeth certificate be axecuted Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Diseasa or injury that initiated avents rasulting in death) Last Dua to (or es a consequance of) been signed by the attending physician should be detached for use as the buna Box 68760, Physician/Medical Due to (or es e consequence of): P.0. 23b. Dtd tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by Division of Vital Records. 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of ceusa of death? certificate has 1 Yas 2 KNO 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician:
Within 24 hours after deeth.
To the Funeral Director: After this certifica 86 25. Was cesa rafarred to medicel axaminar? 26. Placa of Daath (Chack only ona) Hospitel: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Spacify) 1 Yas 2 No 1 Suppatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Tima of 27. Mannar of Death 28c. Injury et Work? 28d. Dascribe how injury occurred 1 Natural 2 Accident 5 Panding Invastigation tnjury 1 Yas 2 No 3 Suicida 6 Could not be datamined 28f. Location (Straet end Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 Homicida 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Cartifiar

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31. Data filed (Marth Day, Yaar) State Registrar

29b. Signatura and titla of certifian

SANKARAN

M. S. Na

M. NAYAR ND 32. Registrar's Signatura

30. Name and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

38 AVE

29c. Licensa number

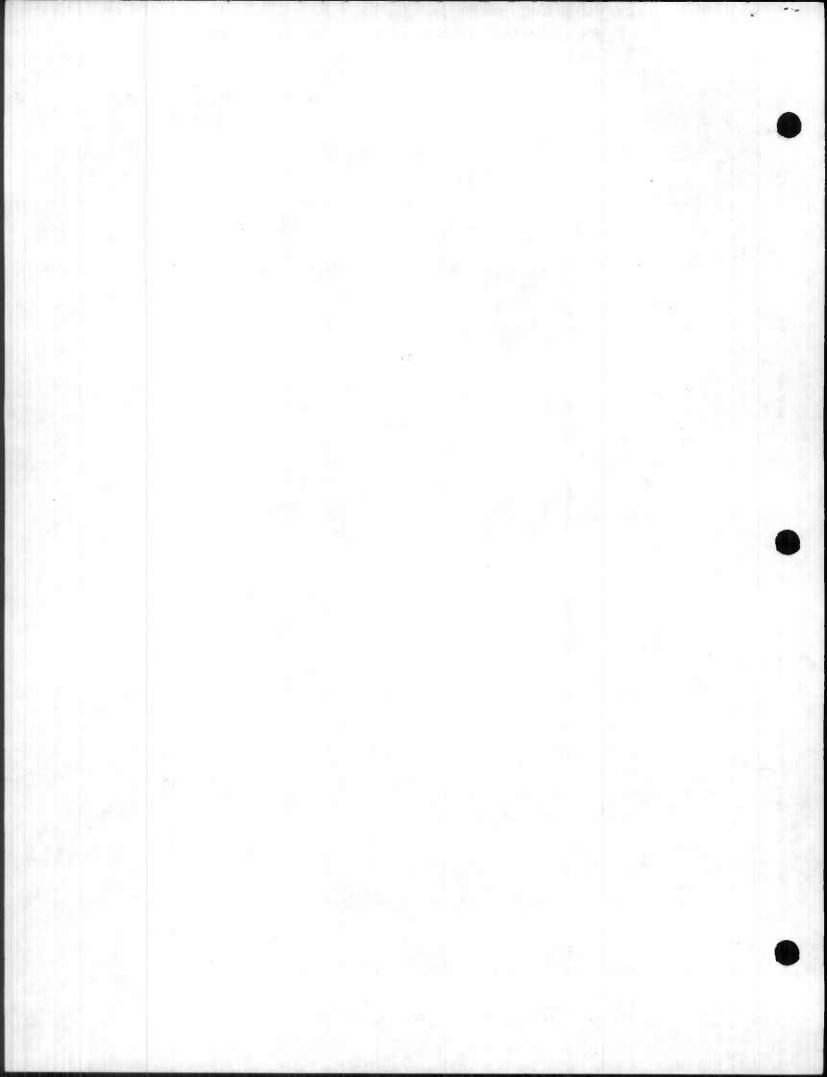
D-17874

BRENTWAD

29d. Data signed (Month, Day, Year)

12.27-00

MD 20722



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

oko Matsus	hir	mu		State of	Marylar		rtment o		alth and M eath		giene Reg. No.	42	2851		
The state of		1. Decedent's Neme (First, Mide	dle, Last)							2. Dete of Dea Month	ath Dey	Year	3. Time of Death		
Physician. /Medical	Kyoko Mat	susl	nima						Decemb			9:30 P.M.			
Examir		4a Facility Name (If not institution	on, give s	street and numi	ber)			4b. 0	City, Town, or Lo	ocation of Death		THE PERSON			
Examin		Suburban Hosp	ital					Be	thesda		Mon:	taame	erv		
Funeval		5. Social Security Number	6. Sex	7	. Age (In yrs.	last birthday)	If Under 1 Ye		Under 24 Hrs.	8. Dete of Birt (Month, De		9. Birth	plece (Stete or Foreign		
Funeral Director		None	10	M 2 F	30		Months Da	ys I	Hours Min.		12, 1970	Cou	ntry) Japan		
Director		Usual Residence of Decedent	1		50				-	repruary	12, 1970		аран		
D 2		10a. State 10b. Count	у		10c. Ci	ty, Town or Lo	cation						10d. inside City Limits		
day day	6	Manyaland Mante			D.	41 4 -							1 ☐ Yes 2X No		
No No.	Directo	Maryland   Mont	gome	СУ	Бе	thesda	104 7th Con	la.		Mh at Cau					
6 8 8	늄	10e. Street and Number			"		10f. Zip Cod				10g. Citizen of V	Allet Con	ntry r		
6 2 9		10309 Montros	se A	venue,	# 201		20	814				Japa	n		
8 8 8	Funeral	11, Meritel Stetus		12. Was Deced Armed Ford		J,S. 13. V	Vas Decedent	of Hispe	enic Origin? (Sp Mexican, Puerto	ecify Yes or No-		a - Ameri	can Indien,		
Maryland 21215-0036 d 2 should be fied within 72 hours after the and Mental Hytigien. T is marked other than "natural", or its traumatic event, the Medical Examina To Be Completed by Fu		1 Never Married 2 Ma	rried	1 ☐ Yes 2 ☒ No						,		. 610.			
		3 ☐ Widowed 4 ☐ Divorce	d	If Yes, Give Yeer or Dat			□ Yes 2🛣	NO 3	эрвспу.		Specify	Jaj	panese		
	peq	15. Decede			ion 16a. Decedent's Usuel C			cupatio	n .		16b. Kind of Bu	usiness/Ir	ndustry		
	ple	(Specify only high Elementery/Secondery (0-12)	-		life. DO NOT use				ng most or work	ing					
	E	—		College (1-4or 5+) 4 Homemake:							Own	ie			
D BER	0 0	17. Fether's Name (First, Middle	, Last)						. Mother's Nem	e (First, Middle,	4 - 6 - 6 - 6 - 6 - 6 - 6 - 6 - 6 - 6 -				
arylan should be and Mental marked o armatic eve	o Be	Tadao Ishiza	awa						Tchiko	Ishizawa					
	۳	19a. Informent's Neme/Reletion		ne Print)		19h Mailin	n Address (Str	(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)							
Mag															
S 20 00 W		Noriyuki Matsushima/ Husband 10309 Montrose Ave., #201, Bethesda, MD 20a. Method of Disposition   20b. Place of Disposition (Name of Date   20c. Location - City or To													
O STORE		1 Burial 2 Acremation 3 Removel from State													
Baltimore, pemit. Pages 1 a Department of Her Important if them any injury or other pince.		4 Donetion 5 Dother (Specify) Montgomery Crematorium, Inc. 24, 2000 Bethesda,										a. M	Tarvland		
		21. Signature of Funeral Service	Clopns	90	22. Name end Address of Fecility Robert A. Pumphrey Funeral										
		1 lethen /	14	I	M006		Wisconsin Ave.								
	$\Box$	23 Per Enter the disease.	or compli	calions that car	,		Bethesd	a, I	Maryland	1 20814-	-3501	1	Approximete		
		234 Per Enter the disease, shoot o heart ailure. Lis	st only on	e cause on ea	ch line.	50 1101 0111	51 (110 1110 00 01	aymig, c		or respiratory of		1	Interval Between Onset end Death		
Physician /Modical		Immediate Cause (Final		11	1 11	2 1		,				- 1			
		diseese or condition resulting in deeth)	8	17	ulhas	la La	june	1							
		resulting in Geeting			Dye to (	or es e conseg	dence of):					1			
D #	ne l					U						1			
nd rans	Examiner	Sequentially list conditions,			Due to (	or es e conseq	uenca of):								
O a a la		if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury													
76 de la particion de la parti	dical	thet initiated events	0		Due to (c	or es e conseq	uence of):								
68 Fice	0	resulting in death) Last										i			
X Conding of the state of the s	3	d													
D ta ta	Physician/M														
S, P.O. BOX (see that the death certify gned by the attending be detached for use a	ysi	Pert il. Other significant condit	ions con	tributing to dea	th but not res	sulting in the ur	nderlying cause	given i	in Part I.	23b. Did	lobacco use co	ntribute	to the cause of death?		
- E										10	Yes 22 No	3 Pro	obably 4 Unknown		
S tra as the be	by														
cord v require been si	Completed									24a. Wes	en eutopsy rmed?	0	Vere eutopsy findings vailable prior to		
Baw re	ple											0	ompletion of cause f death?		
The lay	Eo									100	res 2 No	1	eYes 2□ No		
		25. Was case referred to medic	al le												
f Vital I	o Be	axaminer?	-	26. Place of Death (Check only one)  Hospital: 1   Inpatient 2 ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)											
Phy Phy	-	1 💆 Yes 2 □ No 27. Manner of Death		J L Ini	1 Inpatient 2/2 Et/Outpatient 3 IDOA 4 INUrsin						dence 6 ∐Oth how injury occur		iry)		
	Po	1 □Naturel 5 □ Pend		(Month	Dey Year)	28b. Time of Injury	200.	mjury et Work?	0.50	1 1	ion struct	11	nickuptruc		
Attending r death.	cat	Z Z HOUIGOTIK	tigetion	12-21		17:11			s 25 No	1			0		
	ertification:	3 ☐ Suicide 6 ☐ Could deter	mined	28e. Place o	finjury - At h	ome, ferm, str	eet, factory, off	ica	F 14 4	28f. Location (3 City or Tox	Street and Numb vn, Stete)	er or Ru	rel Route Number,		
D page	0						Street			Marke	ave a Co	ho			

December 22, 2000

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pleca, end due to me ceus (s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

hutes 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year)
DEC 26 2000

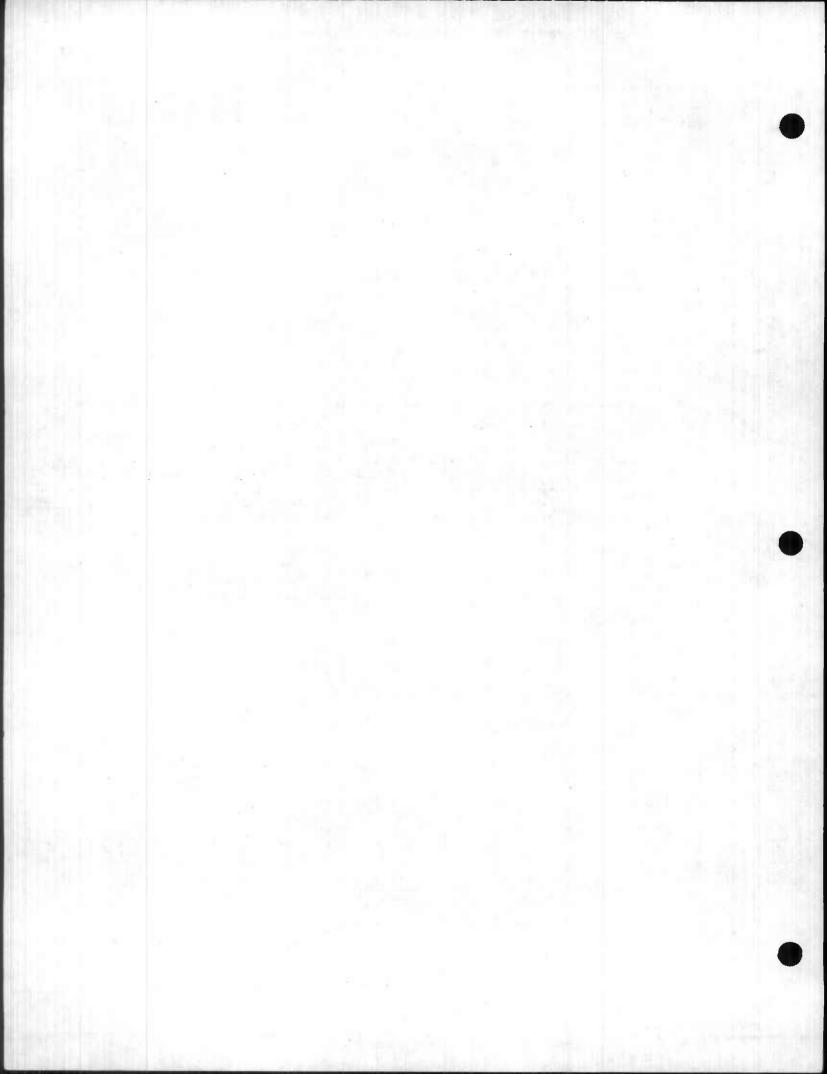
(Check only one)

29b. Signature and title of cartifier

huten 32. Registrer's Signature

oaks

O.C.M.E.



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9:30 A.M HELEN MARSTOI WARD 2000 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth St. Elizabeth's Rehabilitation and Nursing Ctr. Baltimore 5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Day | Months | Days | Hours | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1□M 2XF Aug 6, 1911 332-07-1729 89 Illinois Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 No Yes 2 No Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code #204 21230 100 HarborView Drive USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Ward Mary Curtin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) #204 Margery M. Clark/Step-daughter 100 HarborView Drive, Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 12/29/00 Silver Spring, MD 21. Signeture of Funeral Service Ligansee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final > Lyears disease or condition resulting in deeth) dementia Due to (or as a consequence of): Due to (or es a consequence of) Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown malnutrition 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? obstructive pulmonary disease completion of cause of death? 2 No 1 ☐ Yes 1 Yes 2 No syndrome 25. Was cese referred to medicel examiner? 26. Pigce of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manyler of Death 1 D Natural 28d. Describe how injury occurred

**Physician** /Medical **Examiner** 

physicien end the buriel-transit

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After

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deeth.

Hospital or Attendi
 24 hours after deeth
 Funeral Director: A

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Box 68760

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Records,

Division of Vital

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Examiner

Physician/Medical

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Completed

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Certification:

edical

**Physician** 

\* /Medical

Examiner

Director

Funeral

þ

Completed

Be 10

**Funeral** 

**Director** 

7 is marked other than "naturel", or frems 23s or 28s-f show traumatic event, the Modical Examiner must be notified at

"neturel",

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other frequencies."

the Marylend

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immobility

28a. Dete of Injury (Month, Day Year)

5 Pending Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 Yes 2 No

281. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and menner stated. (Check only one) 29b. Signature and title of certifier

2 Accident

3 Sulcide

29a. Certifier

4 Homicide

29c. License number D28462

December 23, 2000

29d. Date signed (Month, Day, Year)

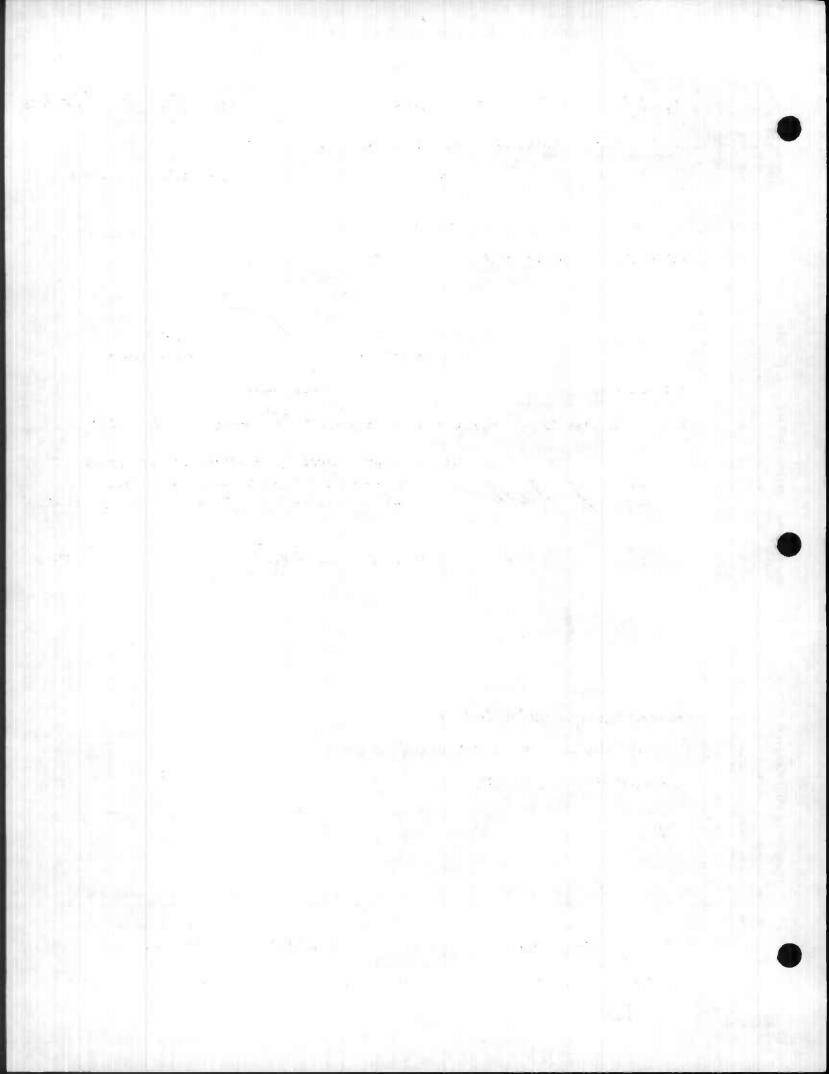
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Boston St Elizabeth Nursina

Center 3320 Benson Avenue

State Registra

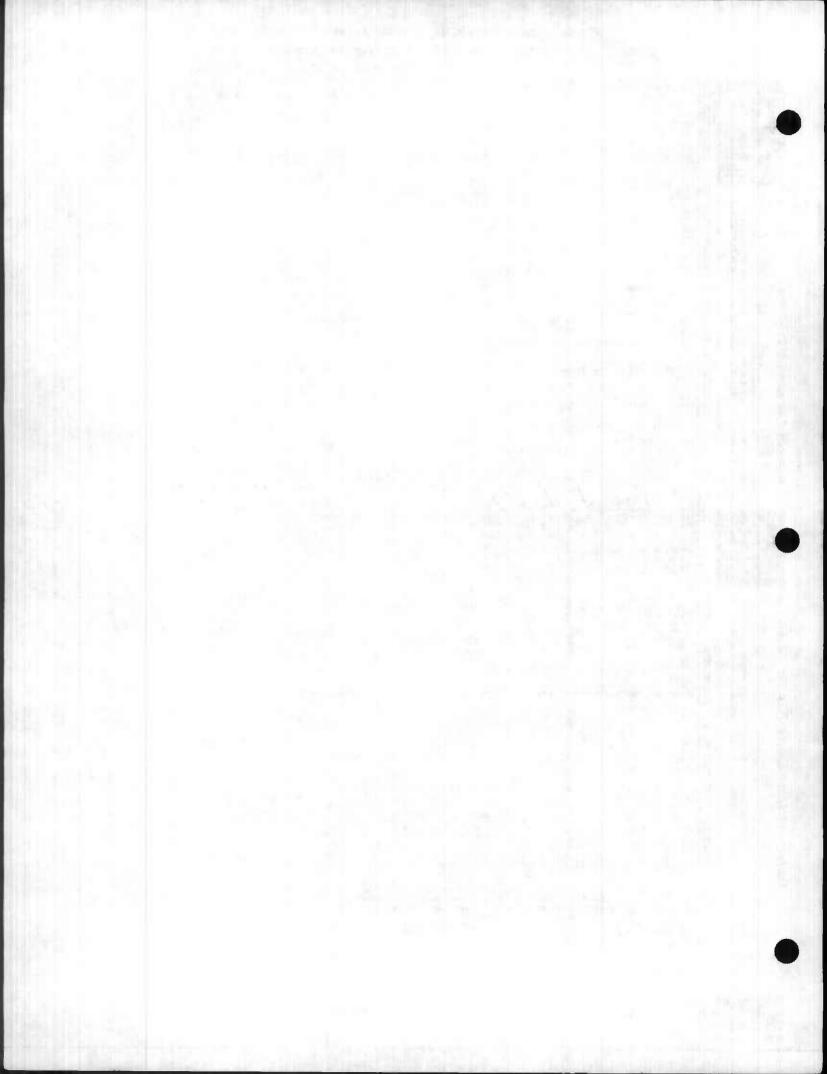
31. Date filed (Month, Day, Year) **DEC 28** 2000 32. Registrar's Signature



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State of Maryland / Department of Health and Mental Hygiene 0 42853

Director    Section   College (1-4or 5+)   College	DO 4:00 pm  Death  Dea				
Joseph Marques   Jose	DO 4:00 pm  Death  Dea				
## Facility Name (If not institution, give street and number)  ## Holy Cross Hospital    Silver Spring   Montgom   Silver Spring   Montgom   Silver Spring   Montgom   Silver Spring   Montgom   Silver Spring   Montgom   Silver Spring   Montgom   Silver Spring   Montgom   Silver Spring   Montgom   Silver Spring   Montgom   Silver Spring   Months   Days   Hours   Min.   May 29, 1917   May 29, 191	Death  IN ETY  Birthplace (State or Foreign Country)  BISSACHUSETTS  10d. Inside City Limits 1 Yes 2 No  I Country?  Where Indian,  White				
S. Social Security Number 017-14-8187	Birthplace (State or Foreign Country) assachusetts  10d. Inside City Limits 1  Yes 2 No a Country?  The Country?  The Country of the Country				
S. Social Security Number 017-14-8187	assachusetts  10d. Inside City Limits 1□ Yes 2☒ No  Country?  Verenicen Indian, White				
Director    Solution   State   10b. County   10c. City, Town or Location	assachusetts  10d. Inside City Limits 1□ Yes 2☒ No  Country?  Verenicen Indian, White				
10a. State   10b. County   10c. City, Town or Location	1 ☐ Yes 2 ☒ No Country?  where Indian, white, etc.				
Elementery/Secondery (0-12) College (1-4or 5+)  Translater McGraw Hi	Country?  where Indian, white, etc.				
Elementery/Secondery (0-12) College (1-4or 5+)  Translater McGraw Hi	umericen Indian, Vhite, etc. Vhite				
Elementery/Secondery (0-12) College (1-4or 5+)  Translater McGraw Hi	Vhite, etc. Vhite				
Elementery/Secondery (0-12) College (1-4or 5+)  Translater McGraw Hi	Vhite, etc. Vhite				
Elementery/Secondery (0-12) College (1-4or 5+)  Translater McGraw Hi	Vhite				
Elementery/Secondery (0-12) College (1-4or 5+)  Translater McGraw Hi	ess/Industry				
Elementery/Secondery (0-12) College (1-4or 5+)  Translater McGraw Hi					
Translater  McGraw Hi  Translater  McGraw Hi  Translater  Joao Marques  Rosalina Goncalves					
Joao Marques  Rosalina Goncalves	111				
Rosalina Goncalves					
E C D C C C C C C C C C C C C C C C C C	- 7'- 0-d-1				
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stell  2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2					
cemetery, cremetory or other place)					
4 Donation 5 Other (Specify)  Gate of Heaven Cemetery 12/23/00 Silver Si	pring, MD				
20a. Method of Disposition  1	C.				
500 University Blvd., W. Silver Spi	ring, MD20901				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.  Physician	Approximete Interval Between Onset and Death				
/Medical Immediate Cause (Final disease or condition resulting in death)  A Hypoxia	one day				
Due to (or as e consequence of):					
Sepsis Pneumonia  Sequentially list conditions, if any, leading to immediate cause Falter Underlying.	one week				
Sequentially list conditions, if any, leading to immediate					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as e consequence of):  Due to (or as e consequence of):	months				
2 2 0 5					
d					
Det II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Pert I.	3b. Did tobacco use contribute to the cause of death'				
1 Ves 2 No. 3	Probably 4 Unknown				
Congestive Heart Failure  Congestive Heart Failure					
performed?	4b. Were autopsy findings available prior to completion of ceuse of death?				
Dementia Stasis Ulcer	1 ☐ Yes 2 ☒ No				
Dementia Stasis Ulcer  26. Place of Death (Check only one)  27. Was cess referred to medicel examiner?  1   Yes 2 N No  28. Place of Death (Check only one)  Hospital: 1   Microsion   3   DOA   Other:   1   Niverion   1   Niverion   1   Niverion   2   DOA   Other:   1   Niverion   2   DOA   Other:   1   Niverion   2   DOA   Other:   1   Niverion   2   DOA   Other:   1   Niverion   3   DOA   Other:   1   Niverion					
	Specify)				
examiner?    Second					
1 Minpatient 2 LER/Outpetient 3 LI DOA 4 LI Nursing Home 5 Li Residence 6 Li Other (3					
1 Minpatient 2 LER/Outpetient 3 LI DOA 4 LI Nursing Home 5 Li Residence 6 Li Other (3					
1	or Rurel Route Number,				
1   Yes 2   No   1   X Inpatient 2   ER/Outpetient 3   DOA   4   Nursing Home 5   Residence 6   Other (state of Linjury and Li	or Rurel Route Number,				
1   Yes 2   No   1   X Inpatient 2   ER/Outpetient 3   DOA   4   Nursing Home 5   Residence 6   Other (state of Linjury and Li	er as stated.				
1 Yes 2 XNo  1 X Inpatient 2 ER/Outpetient 3 DOA  4 Nursing Home 5 Hesidence 6 Other (street and Nursing Home 1	er as stated. due to the ceuse(s)				
The state of local st	or as stated, due to the ceuse(s) fonth, Dey, Year)				
1	or as stated, due to the ceuse(s) fonth, Dey, Year)				
1	for as stated. due to the ceuse(s)  fonth, Dey, Year)				



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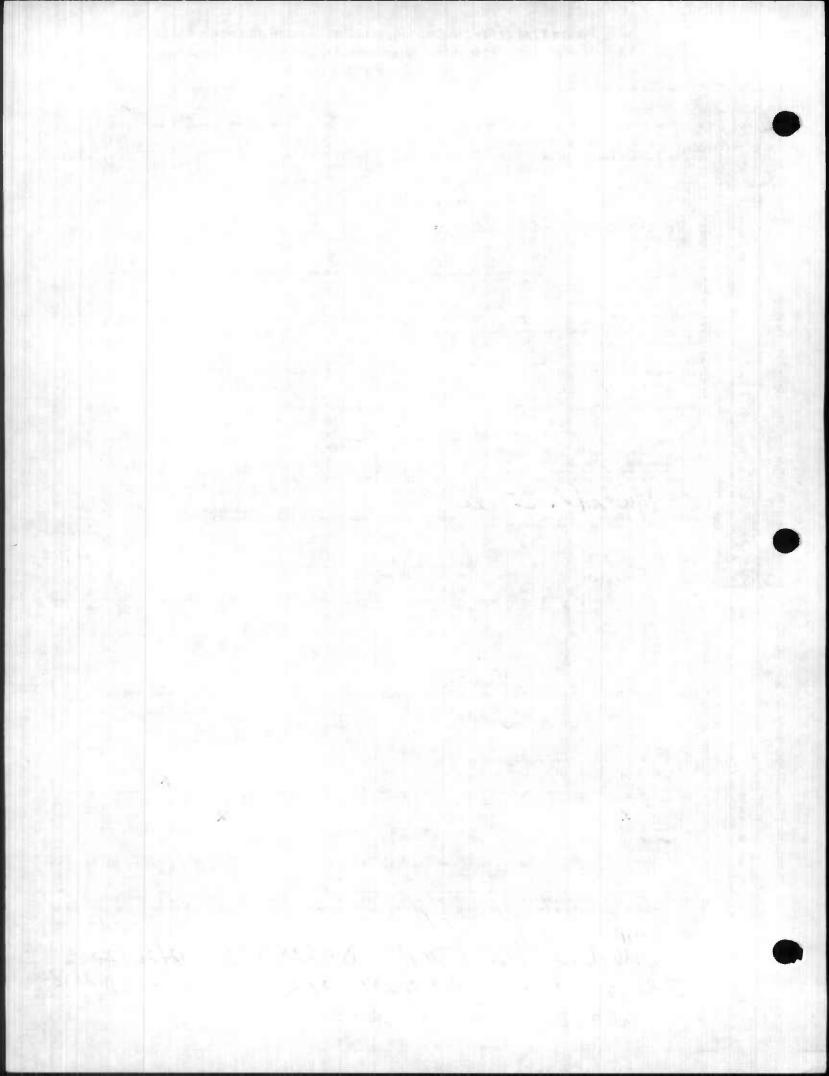
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Ren No 0 4 2851

				Cen	tificate of	Death		Reg. No.	42854
		1. Decedent'a Name (First, Middle, Last	)				2. Date of	Death	3. Time of Death
	Physician	Irene C. Manga	n				Month	Day mber 24,2	11:58 A.M.
	/Medical Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, To	wn, or Location of De		
d	Examine	2905 Tapered Lane				Bowie		Prince	George's
1	E	5. Social Security Number 6. Se		last birthday)	If Under 1 Yea		24 Hrs. 8. Data of	Birth	
L	Funeral Director		DM № 1 66	Yrs.	Months Day	s Hours		Dey, Year) 7, 1934	9. Birthplace (State or Foreign Country) New York
	land	10a. State 10b. County	10c. City	y, Town or Loc	ation				10d. Inside City Limita
	Man, I ah	Maryland Prince G	eorge's Bo	wie					ty⊟Yes 2□No
	vith the Mar or 284-1 a be nouthed	10e. Street and Number	corge o   Do	WIC	10f. Zip Code			10g. Citizen of W	fhat Country?
	3a o	2905 Tapered Lane			20715	5		United S	tates
	r item 234	11. Marital Status	12. Was Decedent Evar in U,	,S. 13. W	as Decedent of	Hispanic Orig	gin? (Specify Yas or		- Amarican Indian,
21215-0020	by by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Year or Datas:		Yes, specify Cu ☐ Yes 2√1 No		, Puarto Rican, atc.)	Specify:	k, Whila, atc. White
5-0	be filed within 72 hor tel Hygiene. d other than "natura avant, the Modell Be Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Decede	ent's Usuel Occ	upation	of working	16b. Kind of Bu	siness/Industry
21	en ".	Elementery/Secondery (0-12)	College (1-4or 5+)	life. D	ind of work don O NOT use reti	red)		Govern	or's Office
2	A transfer	12 2		Sec	cretary				
nd	d oth avan	17. Father's Neme (First, Middle, Last)					r's Name (First, Mide		a)
Na Na	Men Men To	Luigi P. Chevrier				Ca	rmen LeBr	on	
a l	2 sho	19a. Informant's Name/Reletionship (T)					or or Rural Route Nut		
	end eeith n 27	Cece C. Mitchell	Daughter				Bowie Mar	-	
ore	of H of H of H or oth	20a. Method of Disposition  Burial 2 Cremation 3 DF	^	Place of Dispos cemetery, crem	ition (Neme of etory or other p	lece) Dece	ember 29,	2000 Location -	City or Town, State
Ë	Peg ment ant: h	4 Donation 5 Other (Specify)	Ar	lingtor	n Nation	nal Cen	netery	Arlingt	on Virginia
alt	y Interest	21. Signatura of Funaral Sarvice Licens	ea 1 1	22. D.	Name end Add	ress of Facilit	y Funanci	Uomo Ino	
0	88288	Muchall f.	15-16				Funeral Rd. Bowi		
		23a. Part1. Enter tha disaase, or comp shock, or heart tailure. List only o	lication with coused the death	h. Do not ante	r tha mode of d	ying, such as	cerdiac or respirator	arrest,	Approximate
S.	Physician	shock, or heart tailure. List only o	ne called in each line.						Interval Betwaan Onset and Death
d	/Medical	Immediate Cause (Finel	01.00	00					12D 41 x 0
	Examiner	disease or condition resulting in death)	a Wadde	Cance					itmos
L	<u> </u>		D09 10 (0	or as a consequ	delice orj.				
	n and ial-transit	Sequentially list conditions	b	or as a consequ	uence of):			170-111	
o,	execution and an arministration and arministration arministration and arministration arministration arminist	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury							
19	ficete be physicie is the buil	that initiated events	C. Dua to (o	r as a consequ	ance of):				
	o ph as th	resulting in death) Last							
XO	nding use s		d	h					
8	d for d for	Part II. Other significant conditions con	ntributing to death but not res	nivan in Part I	23b. D	ld tobacco use cor	ntributa to the cause of death?		
Baltimore, Marylis  permit. Peges 1 end 2 should  peperment of Heelth and Mer  important: If flam 27 is market  any Injury or other traumatic	y the	Tarris out organization con	givani in tranti						
	E 80						La Piorte	B 100 2010	3 Probably 48 Unknown
	been s should							as an autopsy informed?	24b. Were autopsy findings available prior to completion of causa of death?
Re	has has one 2 one 2 one 2							JYes 2 No	1 ☐ Yes 2 ☐ No
a	ifficate or. pe	25. Was case referred to medical				00 01			10 165 20 140
5	sicle certi	examiner?	Hospital:	Lenio Lenio	C	Wher:	of Death (Check on		(0#1)
of	Phy reld reld	27. Menner of Death		28b. Time of	3 DOA 28c. In	4 U NU	rsing Home 5 R	sidence 6 Liotin	
on	After fune	1 Matural 5 Panding invastigation	28a. Date of Injury (Month, Dey Year)	Injury		lork? □Yes 2□	No		
S	deat deat tor: the	3 Suicide 6 Could not be	28e. Place of Injury - At he	ome, farm, stre				n (Street end Numb	er or Rural Route Number,
<u>S</u>	or A Direction or A	4 Homicide determined	building, etc. (Specifi	(y)	,01,1001019,0110			Town, State)	
	Ne Hospital Ne Funeral pletely filled edical C		sician: To the best of my kno ner: On the basis of examina						
	thin thin the mple	29b. Signatura and file of certifier	and manner stated.	/	29c Lice	nse number		29d. Date signer	d (Month, Dey, Year)
		STM. 1	Alemila	Lan	2 1		0000	12/	1-
	30	Stollered	Numer	onlik	0	00%	>075	1426	2/2000
		30. Name and address of person who	mpleted ceuse of death (Item	n 23a) (Type, F	IMA	81-	-101 0	min	111 20889-
		31. Date filed (Month, Dey, Year)	32. Registrar's Signa	1010	inc	15	10/ , 12	MESDA	S105
	State Registrar	DEC 9 ¢ 200	n Deve	4.	Soork	1			

DHMH 16 Rev 6/95



29b. Signatura and titla of certifier

A Christe no

29c. Licensa number

29d. Data signed (Month, Day, Year)

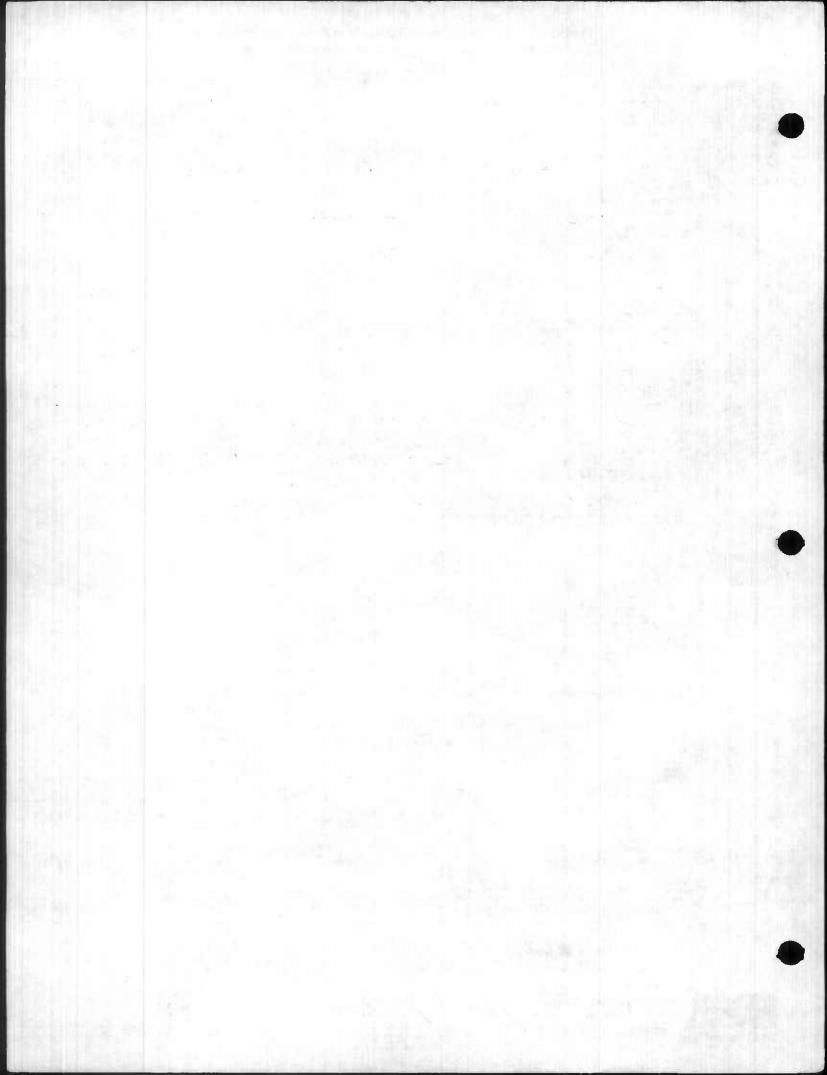
O.C.M.E

DECEMBER 19,2000

30. Nama and addrass of person who complated ceusa of death (Itam 23e) (Type, Print)

Vennis Chutemo 111 Penn Street, Baltimore, 21201

State Registrar



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** lack 1405 2000 Dec /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Baltimore Baltimore Joseph K 5. Social Security Number t060100 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. Month, Dey (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Deys 216.50.0989 1 M 2□ F Yrs Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show traumatic event, the Medical Exerciser must be notified at 1 Ves 2 No Baltimore Funeral Director 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 21216 Avenue 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indien Bleck, White, etc. 11 Marital Stetus ☐ Yes 250 No Yes, Give filed within 72 hours efter 1 Never Married 2 Married 8 Maryland 21215-0020 1 ☐ Yes 2 No Be Completed by Black 3 Widowed 4 Divorced Yeer or Dates 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry end Mental Hygiena. econdery (0-12) Cottege (1-4or 5+) Employment unknown 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Peges 1 end 2 should be nent of Heelth end Mental unknown Geraldine 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end 2 Department of Heelth e Important: If Item 27 Is Bathmore, MD 21216

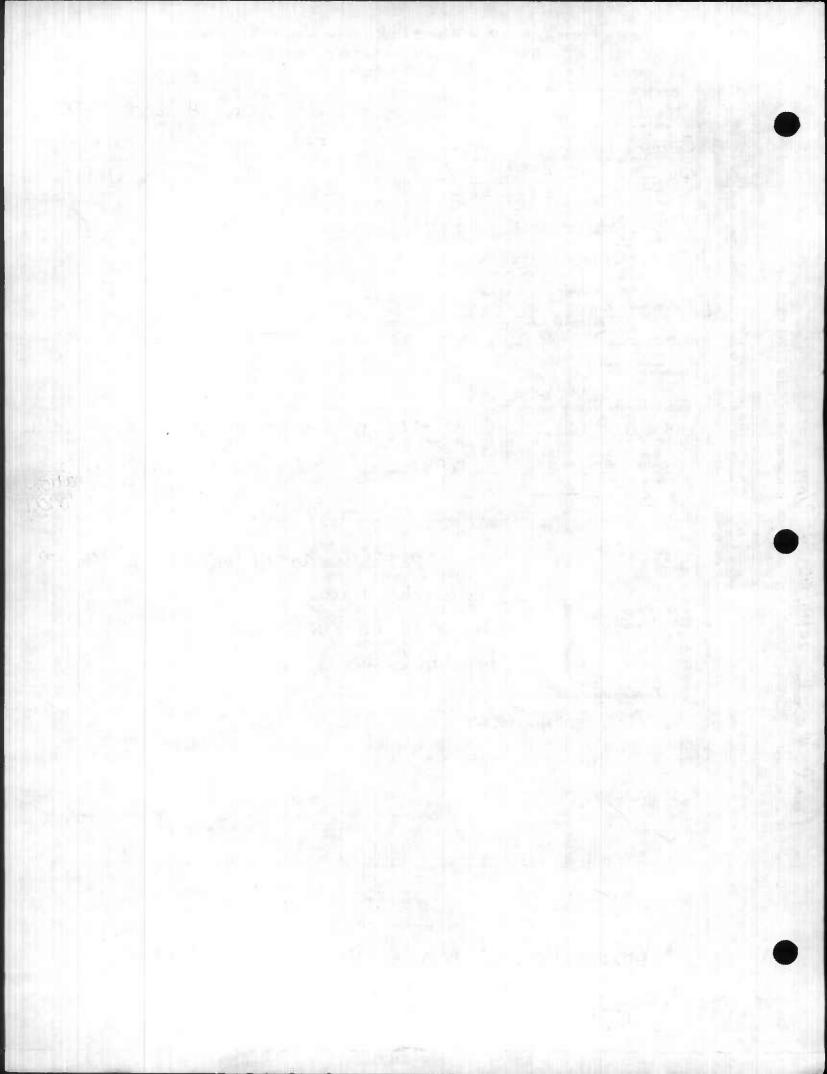
20c. Location - City or Town, State daughter Angela 1 Baitimore, 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State aurel, MD 4 Donetion 5 ☐ Other (Specify) any injury 22. Name and Address of Fecility Anatomic 21. Signature of Funeral Service Licensee Gift Foundation Baltimore 2000 Approximete Interval Between Onset end Death 23a. Pen1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** transdiete Ceuse (Finel diseese or condition resulting in deeth) /Medical **Examiner** Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest the funeral director, page 2 should be detached for use as the burial-trar elle Due to (or as a consequence of): pant Pert II. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Dld tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Onknown After this certificate hes been signed by hypercal come Medical Certification: To Be Completed by 24b. Were eutopsy findings aveitable prior to completion of ceuse of death? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) + 65016 1 Yes 2 No 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) completaly filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the cause(s) end manner steted. 29e. Certifier **\$** 29c. License number 29d. Dete signed (Month, Dev. Year) 29b. Signeture end title of certifier 2114 100 003574 MM allowine Harrism Harrison, 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Katherine Suban Ber 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State DEC

Registrar

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Data of Death Month Year NASR 0918 A FAHD M. December 52 2000 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ROCKVILLE MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ff Under 1 Yaar Months Deys If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 1, 1912 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Deys 1⊠M 2□ F Hours 242-35-2893 88 Lebanon Usual Residence of Deceden 10a. State 10c. City. Town or Location 10b. County 10d. toside City Limits 1 Nes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 303 Palm Spring Drive #9 United States 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes ≥ 2 ☒ No If Yes, Give Yeer or Detes: 14. Race - Amarican Indian, Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Merital Stetus Bleck, White, etc. 1 ☐ Nevar Merried 2 Married 1 Tyes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Automobile Parts Elementery/Secondary (0-12) 1 2 College (1-4or 5+) Company 0wner 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Masoud Nasr Latifa Farah 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 303 Palm Spring Dr. #9, Gaithersburg, MD 20878 Hoda Nasr/Daughter Dec. 29, 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stete Montgomery Crematorium, Inc. 2000 Bethesda, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee ROBERT A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 23a. Pentl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, Approximate tnterval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) Small bowel obstruction 3 DAys Due to (or es a consequence of): 3 DAY J Prenmonia Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury congestive heart Fallure 10A4 that initieted events resulting in death) Lest Dua to (or as a consequence of): 23b. Dtd tobacco use contribute to the cause of death? Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown COLON CANCER braw Fulring 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? BLADDER CANCER Parkinson Disese 1 Yes 20 No 1 Yes 25 No 25. Wes case reterred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: N2Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Deeth 1 Netural 28a. Dete of tnjury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation

ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the death certificate be executed The law requires that Division of Vital Records. After this certificate has usion Afternates after death.

Aura sher death.

Area Director: After this certiin.

And in by the funaral director, pr To the Hospital o within 24 hours af To the Funeral Di completely filled is

**Physician** 

/Medical

Examiner

Directo

Funeral

à

Completed

Be

**Funeral** 

Director

filed within 72 hours after death with the Maryla Hydjone. Whet Itan \*rabarel; or literie 23e or 28e-f ethor wit, the Medical Examine mast be notified at

should be Marrial

Baltimore,

Brid

permit. Pages 1 and 2 st Capartment of Health and Important: If Item 27 is in any Injury or other traum

**Physician** 

/Medical

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Physician/Medical

by

Completed

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Certification:

Medicai

marked

Registrar

2 Accident

3 ☐ Suicide

29e. Certifier

4 \ Homicide

(Check only one)

29c. License number D18726

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as stated.

2 Medicat Examiner: On the bests of axamination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Arthur Schoengold, M.D. MARY LAND /18111 Philip DR GLNEY 32. Registrer's Signeture

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

31. Data filed (Month, Day, Year)

29b. Signature and title of certifiar

DEC 29 2000

6 Could not be determined

reperson

oaks

Late M quality

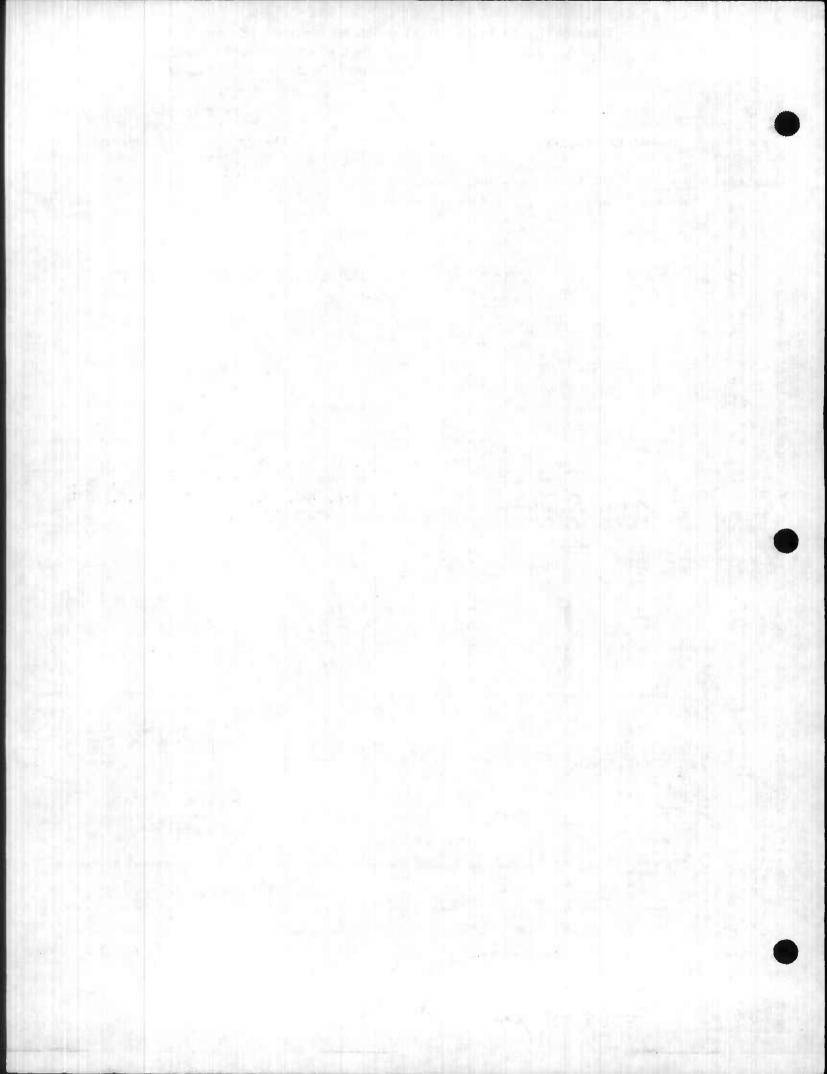
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

						Ce	ertifica	te of	Death			Reg. No.	U	2000		
		1. Decedent's Nan	ne (First, Middle, La	ist)							2. Date of D Month	eath Dev	Yeer	3. Time of Death		
	Physician /Medical	Bonnie	G. Ostro	om									13,200	0 4:55 PM		
	Examiner	4e Facility Neme	(If not institution, given	re street and num	nber)			- 1	4b. City, To	own, or Lo	cation of Dea		ounty of Deat			
		Suburb 5. Sociel Security	oan Hospit		7. Age (In yrs.	last hirthday	a) If Unde	or 1 Yeer	Be	thes	R Date of Bi	inth	ontgome	<u> </u>		
	Funeral Director	331-07	-2020	1  M 2	7. Age (in yrs. 84	Yrs.	Months		Hours	Min,	(Month, D) Feb. 5	, 1916	5 II	hplace (State or Foreign Junity) linois		
	pu »	Usual Residence of	of Decedent 10b. County		10c Ci	h. Town or I	contion			-				10d. Inside City Limits		
	Maryie a-f shout offed at	MD Montgomery 10c. City, Town or Location Bethesda										1 ☐ Yes 2₺ No				
	efter death with the Maryland or items 23a or 28a-f show refres must be notified at Funeral Director	10e. Street and Nu 6904	River Ro	ad			10f. Zi	p Code	2	0816		10g. Citizen of What Country? USA				
	fler death v	11. Meritel Status		12. Was Dece	dent Ever in U	,S. 13.	. Was Dece	edent of H	lispanic Ori	igin? (Spe	ecify Yes or N Rican, etc.)	0- 14	. Raca - Ame			
مرج on of Vital Records, P.O. Box 68760,	2 should be filed within 72 hours efter and Mental Hygiene. Is marked other than "naturel", or the raumatic event, for Medical Exercite. To Be Completed by Fur	1 ☐ Never Mar 3 ☑ Widowed	ried 2 Married	Armed For 1 Tyes If Yes, Give Year or Da	2 ⊠ No e		1 ☐ Yes		Specify:		Hican, etc.)		Black, White			
2 0	ed within 72 hoygiene. Nor than "nature. It, the Modell	/000	15. Decedent's E	ducetion	-	16a. Decedent's Usual Occupation					ina	16b. Kind of Business/Industr				
275	Phin 7	Elementary/Sec	condery (0-12)	College (1-	-4or 5+)	(Give kind of work done during most of workin life. DO NOT use retired)										
	s 1 end 2 should be filed within them 27 is marked other than other traumatic event, the To Be Comp			2		Administrative Assistan					t	Publ	lic Scl	nools		
o Pu	tai Hy d oth		(First, Middle, Last			18. Mother's Name					(First, Middle	e, Maiden Su	ımame)			
1	should to marked umartice	Robert	Paul Gall	raith					M	largo	Eliza	beth D	urman			
	2 sho and is me	19a. Informant's Name/Relationship (Type, Print)  19b. Meiling Address (Street and Number or Rural Route Number, City or Town,									Town, Stete, 2	(ip Code)				
	of Health item 27 other tr	Robert	G. Ostro	n – Sc			Ridg		eld Ro	oad	Bethe	sda, 1		816		
	or oth	20a. Method of Dis	sposition	Domaval from 6		Place of Disponentery, cre	position (Na ematory or	me of other plea	ce)		Date	20c. Loca	ition - City or	Town, State		
E. E	Pariti		5 Other (Special		Ar1	ingto	n Nat	ional	l Cem	. 1	/2/01	Arlin	gton,	Virginia		
•	permit. Pag Depertment Important: I any Injury o	21. Signature of F	uneral Service Lice	nsee		2	22. Neme a	nd Addre	ss of Facili	ity Jos	eph Ga	wler's	Sons	Inc.		
	Dep	Tho	man E	2	In Sto						_			20016		
		23e. Pert1. Enter shock, or he	23e. Pert 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.  Approximate Interval Between Onset end Death													
	Physician // // // // // // // // // // // // //															
	Examiner	disease or condition a. IPPTIC I South, 2 days												2 dass		
	100	Due to (or as a consequence of):  Acute Renal Failure 2 dass														
6	nin nsit			b					Fai	lune				2 8455		
	ate be axecuted hysicien end the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury c. Metabulic Encephalopathy 2 days														
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	flicate be physicie as the bur edical	resulting in death)	Last		Due to (o	or as a conse		:	,	, ,			7			
×	onding pluse as t	a. Gram Negative Uninary Tract Intestion														
Bo	attendii I for use							-								
Ö	at the death ce d by the attendi eteched for use Physician/	Part II. Other signi	ificant conditions	contributing to de	ath but not res	ulting in the	underlying	cause giv	en in Pert	1.			_	to the cause of death?		
0	The lew requires that the death certificate be axecuted ate hes been signed by the attending physicien end pege 2 should be deteched for use as the burial-transit Completed by Physician/Medical Examir	February 18 1 16 1111 1 -										obably 4 ☐ Unknown				
sp.	uiras id be			al 7		/,					24a. We	s en autopsy	y 24b.	Were autopsy findings		
Ö	The lew requir		Atu	al 7	2,600	1/44	on				per	formed?		eveilable prior to completion of cause of death?		
Re	hes de 2 de 2 de 2 de 2 de 2 de 2 de 2 de												/			
<u>a</u>	ysician: The list certificate he director, pege											Yes 2	No	1 ☐ Yes 2 ☐ No		
\frac{2}{5}	clan sector	25. Wes cese refe examiner?		Hospital:				Oth			Check only					
P.O. Box	2 2 2 7	1 Yes 2 2		1 1 1	•	ER/Outpatie		UA	4U N		me 5 Res		-	city)		
_ E	After funer	1 Matural	5 Pending		of Injury h, Day Year)	28b. Time Injury		28c. Injur			28d. Describe	o now injury	occurred			
sic	Attending in death.  ector: Afte by the fune liffication	2 Accident 3 Suicide	Investigatio		***		М		Yes 2		Oot Leasting	(Chront and	Al-mharas (1	on ( Davida Alventra)		
Σ	tal or Attending P is after death. In Director: After the ed in by the funers Certification:	4 ☐ Homicide	determined	209. Place	of Injury - At hing, etc. (Specif	ome, tarm, s fy)	treet, factor	ry, office			City or To	own, Stete)	Number or A	ural Route Number,		
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	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funerel Medical Certification	29a. Certifier (Check only one)	1 Certifying Pt 2 Medicat Exam	niner: On the ba and mann	sis of examina	ition and/or i	nvestigation	n, in my o	pinion, dea	ath occurr	ed at the time	, dete and p	lace, end due	to the ceuse(s)		
	Me the	29b. Signeture end	d title of certifier	und mann	/		29	c. Licens	e number			29d. Date	signed (Mont	h, Day, Year)		
			Lot A	1. 91				D		076	10			23,2000		
	10	/		4 -6	~~						0	rece	in Ren	2 3 2000		
		30. Name and add	Iress of person who	completed ceuse	e of death (Iter	n 23a) (Type	e, Print)		0		0 11	,	1.4			
		31 Dete filed (Man	oth Day Year	MD 86	anistrar's Sinn	d Geo	orget	own	Ko	ad,	ISEThe	sda	Mary	land		
	State Registrar	חב	cr CHAN, nth, Day, Year)	n Bes	errar	B.	Loon	KS								

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

						C	ertificat	e of	Death	1		Reg. No.	i d	4000	)	
		1. Decedent'a Nama (First, Middla, Last)										eath Day	Year	3. Time of I	Deeth	
III e	Physician /Medical	Marion K. O nara										er 24,	2000	6:47	PM	
	Examiner	An Couldn't Name (If not institution aire street and overhead)									ocation of Deat	h 4c. Count	y of Death			
180		Suburban H	lospita	a1					Beth				tgome	ery		
184	Funeral	5. Social Security Number			7. Age (In yrs.		y) If Undar Months	1 Yaar Days	If Undar Hours	24 Hrs. Min.	8. Dete of Bi (Month, De March 2	rth ey, Year)	9. Birth	oleca (Stete or	Foreign	
	Director	568-10-7981		☐ M 2☑ F	90	) Yrs.		,-			March 2	8, 1910	Min	nésota		
	8 8	Usual Residence of Dece	County		10c Ci	ty, Town or	Location						1.	IOd. Inside City	n Limits	
	athor a		ntgome		100.0									1 ☐ Yes		
	or 25s-f a be notified	10e. Street and Number	nicgoille	ELY		Kell	singto					10g. Citizen of What Country?				
			ne Mar				101. Zip		895			United				
	her death v r here 23s siner mast Funeral	11. Marital Statua	ms way		edent Evar in U	15 15	Was Decer			rigin? (Sn	acity Vas or N		ca - Americ			
	Pun Pun	1 Never Married 2	☐ Married	Armed F	orces?	,,5.	If Yes, spec	cify Cuba	an, Mexica	n, Puarto	ecify Yas or No Rican, etc.)	Ble	ack, White,			
020	A NO.	3 ™ Widowed 4 □ D		If Yes, G	ive	000	1 Yas	2 🖾 No	Specify	:		Speci	ily: W	Thite		
9	thurs of			16a Decedent's Heuri Occupation						16b. Kind of f	Business/In	dustry				
215	ad within 72 to ygiene. we than "netur it, the Medical.	(Specify onl	(Specify only highest grade completed)  Eternentery/Secondery (0-12) College (1-4or 5+)					(Give kind of work done during most of working life. DO NOT use retired)								
27	piono piono	2 Assistant Director									America	n Red	Red Cross			
P	tal Hyg d other event,	17. Fathar's Nama (First, Middla, Last) 18. Mother's Na								er's Nam	me (First, Middla, Meidan Sumeme)					
/a	though be filled of Mental Hyg of Mental Hyg other marked other matic event,	Matthew Mehalsick Nora Du								a Du	aggan					
Maryland 21215-0020	2 sho and 3 sums sums	19e. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street end Number or Ru									ral Routa Numb	er, City or Town	n, Stete, Zij	Code)		
	2557	Donna M. Young/Niece 5123 Wickett Terrace,									Bethesd	la, Mary	land	20814		
more,	of Heart	20a. Mathod of Disposition  20b. Placa of Disposition (Name of cametery, cremetory or other piece)  20b. Placa of Disposition (Name of cametery, cremetory or other piece)  Dec. 2										20c. Location - City or Town, State				
Ĕ	Page m. m.	4 Donation 5 C			State		y Crema			ic.	Dec. 28, 2000	Bethes	da, M	arylan	d	
Balti	Party Start	21. Signeture of Funeral	Service Licen	see		P	22 Name en	d <sub>A</sub> Addre	ss of Facil	ity .						
14	Deg Man	1 Route	tuck	-	M001	98 7	557 Wi	sco	nsin	Aven	ue 20814-	Home/E	Chas	e, Inc	• 9	
17		23a. Part1. Enter the disc shock, or sear feilu	ase, or comp	plicetions thet		1.20								Approximate Intervat Betw	3	
	Physician	SHOOK, OF MARKET FORD	e. List Offig	ONE CAUSE ON	each line.									Onsat and D	eath	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician Enoch Wilson Price** 07:31 AM December 21, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sacred Heart Hospital Allegany Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Months Days 10 M 20 F 217-14-4374 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow edical Examiner must be notified at 1 Yes 2 No Director Allegany Maryland Frostburg 10e. Street and Number 29 West College Avenue 10f. Zip Code 10g. Citizen of What Country? 21532-Pages 1 and 2 should be flied within 72 hours after death neat of Heath and Mental Hyglene.

11. Hear 27 is marked other than "natural", or Herma 23 into other traumatic event, the sendes frammer many or other traumatic event, the sendes frammer many. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1□ Yes 20XNo Specify Specify: White g 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp grade completed) Elementary/Secondary (0-12) College (1-4or 5+) President beer distributor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 **Enoch Prichard Price** Melissa Wilson Price 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Price 21532-29 West College Avenu Frostburg Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State pemil. Page Department of Important: If any injury or once. Frostburg Memorial Park 24-Dec-00 Frostburg, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 234. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician 10 /Medical Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest minutes Examiner Due to (or as a consequence of): 48 Examiner Respiratory Failure hours physician and the burial-transit The law requires that the death certificate be asseuted Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Amyotrophy Lateral Sclerosis 12 years Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Ventilator dependent Records, ð 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy CABG History certificate has b 1 ☐ Yes 2 ☑ No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1☐ Yes 2☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 € DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending investigation 1 Matural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide \*\*Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 40053855 MATHAINE December 23,2000 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stanley Joseph Matyasik, M.D., 900 Seton Drive, Cumberland, Maryland 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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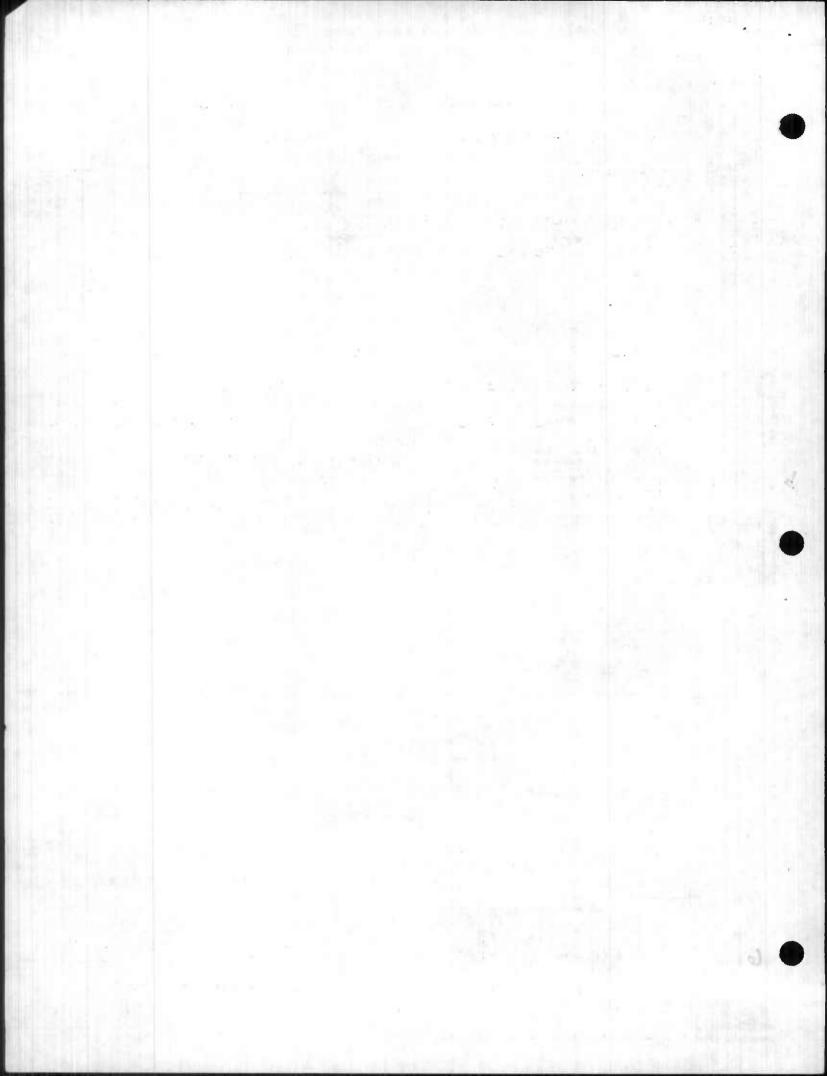
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32. Registrer's Signeture

DEC 28 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 20 Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth **Physician** Roger Raymond Poole December 4, 2000 0716 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel George J egional Hospital If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Dey, Year) January 21, 1935 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 217-32-0968 1⊠M 2□ F Yrs. 65 Director Maryland Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after deeth with the Manylan neat of Heelih and Mentel Hygiene.
ant: If item 27 is marked other than natural, or itema 23a or 28a-f show my or other than interest about the insurance or other trainments avent, the Mentel Earn's or other trainment avent, the Mentel Earn's or other trainment avent, the Mentel Earn's or other trainments. 1 ☐ Yes 2X No Director Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10031 Clue Drive 20817 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Meritel Status 1⊠Yes 2□No 1953-If Yes, Give Year or Dates: 1956 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Wholesale 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Roger Raymond Poole Alta Young 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Carolyn G. Poole, Wife 10031 Clue Drive, Bethesda, Maryland 20817 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State December permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 27, 2000 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue M00689 Bethesda, Maryland 20814-3501 be, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. nt1 E tel the diseas Approximate Intervel Between Onset and Death **Physician** Arterioseferatic Cardiovaseular Disease /Medical Immediate Cause (Finet disease or condition resulting in death) Examiner Examiner sician and burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of). physician the buria Box 68760, Physician/Medical Due to (or as e consequence of): 980 P.O. Part ff. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vitai Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1- Netural Division or Attending 5 Pending investigation To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edical (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 35+ H0053527 December 22 2000 20 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Cheverly, MANyland 20785

**DHMH 16 Rev 6/95** 

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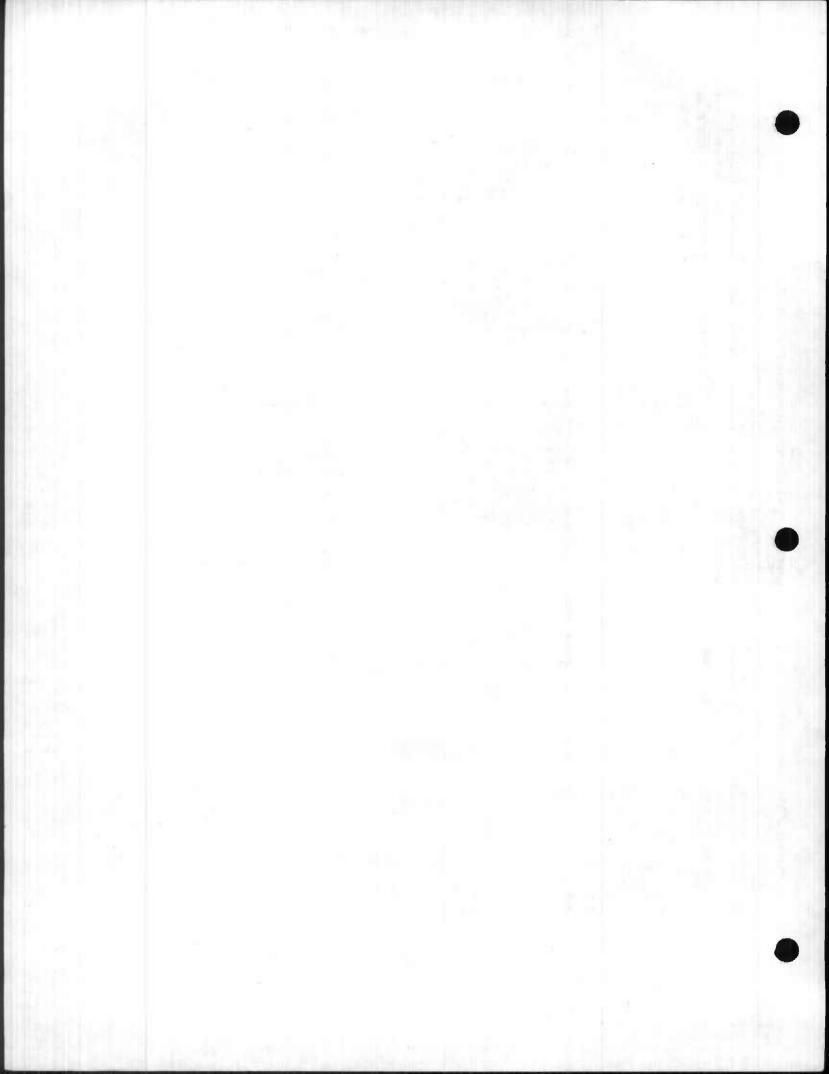
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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month DEC **Physician** 0900 PM 2000 Vaughn Pinkney Lorraine /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Myrsing Home Baltimore Manor 7. Age (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 8. Date of Birth May 2, Year 20 5. Social Sacurity Number 9. Birthplaca (State or Foreign Ballutry) Md. **Funeral** Months 214-18-3315 1□M 219 F Days Hours Director Usual Rasidanca of Dacedani the Merylend 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits tem 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 X Yas 2 No Director Baltimore 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 333 North Grantley Street 21228 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 20 No If Yas, Giva Year or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian. Black, White, atc. 2 should be filled within 72 hours after and Mental Hygiena. 1 Nevar Married 2 Married Specify: Black 1 Yas 2 No Specify: p 3⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Day Care Mother Child Care 18. Mothar's Nama (First, Middle, Maiden Sumeme) 17. Fethar's Nama (First, Middle, Last) William Grayson Alberta Spottswood Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health and Library of Health and Important: If item 27 is many injury or other treum once. Dorothy Ross/Niece 2037 Chadwick Terrace Temple Hills Md 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place)
Maryland National 20c. Location - City or Town, Stata 20e. Method of Disposition Data Burial 2 Crametion 3 Removel from State 1/02/01 Laurel, Md. 4 Donation 5 Othar (Specify) 21. Signature of Fyneral Service License 22. Nama and Addrass of Facility Philip D. Rinaldi Funeral Service 11818 New Hampshire Ave. Silver Spring, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardlac or respiretory errest, shock, or hear failure. List only one ceuse on each line. Approximata Intarval Between Onsat end Death **Physician** Hemorrhage Intra cranial Immediate Cause (Finel disaasa or condition resulting in daath) 2 Weeke /Medical Examiner Dua to (or as a consequence of) Examiner attending physician and for use es the bunel-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disease or injury that initieted events resulting in deeth) Lest Dua to (or es a consequence of): Physician/Medical Dua to (or as a consaquance of): 98 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown eizyves Division of Vital Records, þ 99 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed this certificata hes 2 No 1 ☐ Yes 2 ☐ No 1 Yas 25. Was casa raferrad to medical Be 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No To 27. Menner of Deat 28c. Injury at Work? 28d. Dascribe how injury occurred s after death.

I Director: After tild in by the funara Certification: 1 Natural 2 Accidant 5 Pending invastigation 1 Yas 2 No 6 Could not be detarmined 3 Suicida 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funerel Di completaly filled in 29a. Cartifiar Certifying Physician: To the bast of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. Medical 29d. Data signad (Month, Day, Year) 29c. Licansa number 29b. Signeture and title of certifier 00052940 LOK. MD 15 30. Name and eddress of person who completed causa of deeth (Item 23a) (Type, Print) Geeth (Hem 23a) (Type, Print) \$21 N. Eutzw # 407, Baltimore, MD 2/20/ P. SHAH, ND

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31. Dete filed (Month, Day, Year)

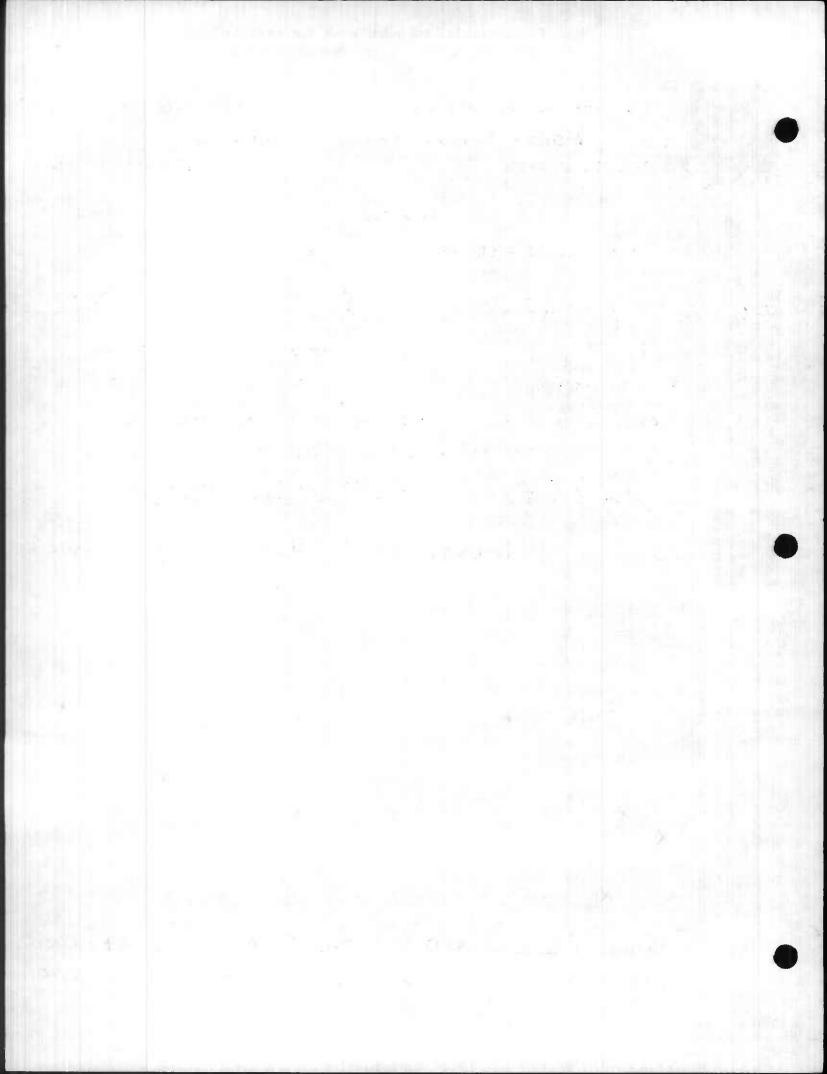
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32. Registrar's Signatura

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Veel 28, DEC. 1:00 AM VELMA 2000 F. PHILLIPS 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth MONTGOMERY SLIGO CREEK NURSING AND REHAB. CENTER TAKOMA PARK 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Dey, Yeer) 9. Birthplece (Stete or Foreign Days 1 M 2 TF 10, 577-10-1709 1911 VIRGINIA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1M Yes 2 No PRINCE GEORGES RAINIER 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4506 32nd ST. 20712 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify 3 Widowed 4 □ Divorced WHITE 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 WOOLWORTH'S STORE PERSONNEL SUPERVISOR 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) V. COMER WILLIAM McDANIEL PERMIT 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) U.S. HIGHWAY 340, SHENANDOAH, VA. 22849 ELWOOD McDANIEL/BROTHER 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 □ Cramation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) NATIONAL MEMORIAL PARK 12/30/00 FALLS CHURCH, VA. 22. Neme end Address of Facility 21. Signature of Funarai Service Licenses 5801 CLEVELAND AVE. CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Final disease or condition resulting in deeth) 13/000 Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in daeth) Lest Due to (or es a consequence ol) Dua to (or es a consequança of): 23b. Did tobacco use contribute to the cause of death? 2D No 3 Probably 4 Unknown stenosis/regurgitation, atrial 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? fibrosis dementer 2000 1 ☐ Yes 1 ☐ Yes Yasculer. 25. Was case referred to medi exeminer? 26. Piece of Death (Check only one) Other: Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28e. Dete of injury (Month, Dey Year) 28c. Injury et Work? 27. Mapner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Yas Investigetion 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

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/Medical

Examiner

**Funeral** 

Director

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Baltimore, Maryland 21215-0020

Pert II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

1 Naturel 2 Accident

29a. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted.

29b. Signeture and title of certifier eddress of person who npleted cause of deeth (Item 23e) (Type, Print)

29c. License number

29d. Dete signed (Month, Dey, Year) Road Hyattsville MT 20752

State Registrar

6525 31. Date filed (Month, Day, Year) 32. Registrer's Signature **DEC 29** 

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth Month 27,2000 December 12:15am

**Physician** /Medical Examiner

**Funeral** 

Director the Maryland 28a-f show ò 238

raumatic event, the Medical Examiner must be notified at wernit. Pages 1 end 2 should be filed within 72 hours efter death variant of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

**Physician** /Medical Examiner

Examiner

The law requires that the death certificate be executed physician end the bunal-tran 89 for use es signed by the page 2 certificate or Attanding Physician: uneral efter death.

I Director: Af in by the fu the Funeral Director filled in by

1. Decedent's Name (First, Middle, Last) Anthony Peter 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mariner Health of Kensington Kensington Montgomery 6. Sex **X**□ M 2□ F If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Day, Ye Aug. 24, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 041-54-7685 64 Vrs India Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Montgomery Gaithersburg Director 10e. Street and Number 450 Girard Street 10f. Zip Code 20877 10a. Citizen of Whet Country? U.S. Perm. Resident Funeral 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 Yes 2X No It Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: Asian g 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Safeway Food Stores Bakerv 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Moonsam Peter Mary Ratnaswamy 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meena Barua/Sister 5812 Oland Dr. New Carrollton, Md 20784 20b. Plece of Disposition (Name of cametery, crematory or other plece) 20a. Melhod of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Cremator 12/28/00 Alexandria, Va. 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Philip D.Rinaldi Funeral Service 11818 New Hampshire Ave. Silver Spring, Md 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hem failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting In death) d montes ncoros Due to (or as a consequence ot): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca ot) Physician/Medicai Due to (or as a consequence of): Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes No No 3 Probably 4 Unknown

λq Completed 24a. Wes an eutopsy 24b. Were eutopsy tindings available prior to completion of cause of deeth? performed? ZXNO 1 Yes ONO 1 Tyes Be 25. Was case reterred to medical exeminer? 28. Plece of Deeth (Check only one) Hospital: Certification: To 1 Yes No Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner stated.

(Check only one) 29b. Signeture and title of certitier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Dophren Genlin, mo

December 27, 2000 DAPHNA HE

1 X Yes 2 No

2309 S Gueld Rocal C

31. Date tiled (Month, Day, Year) 2000 **DEC 29** 

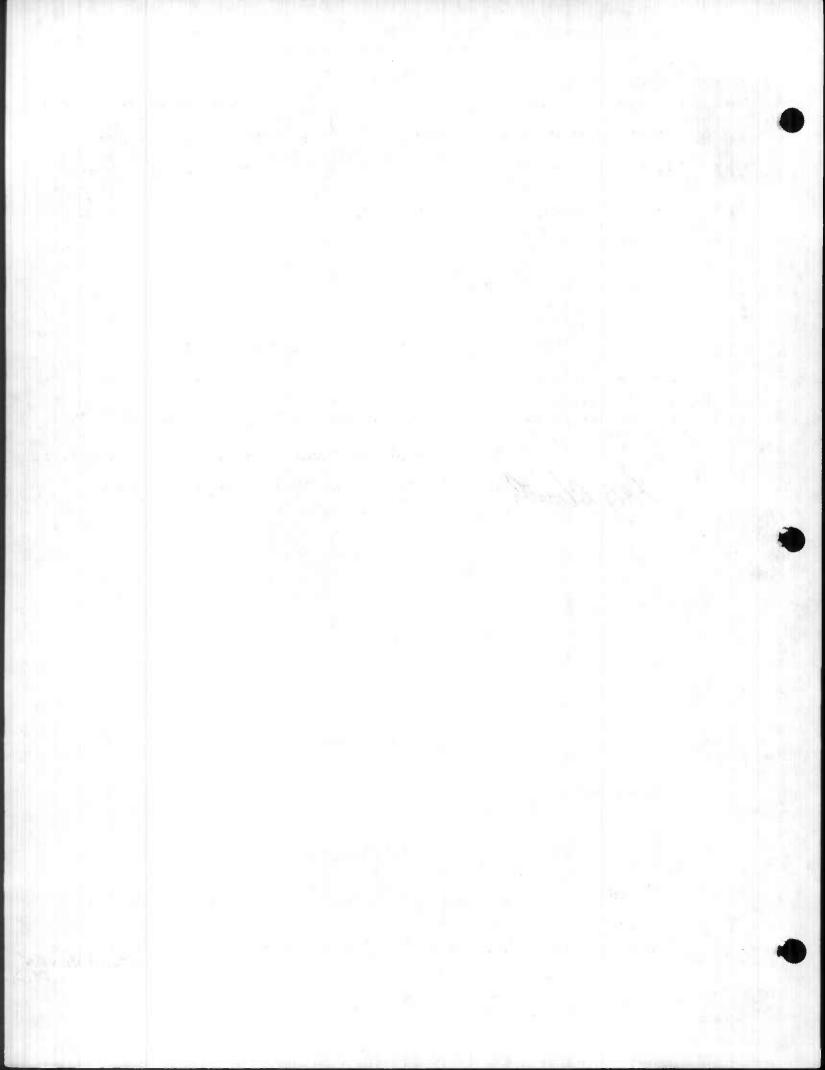
32. Registrar's Signature

early ms

State

Registrar

Within 2



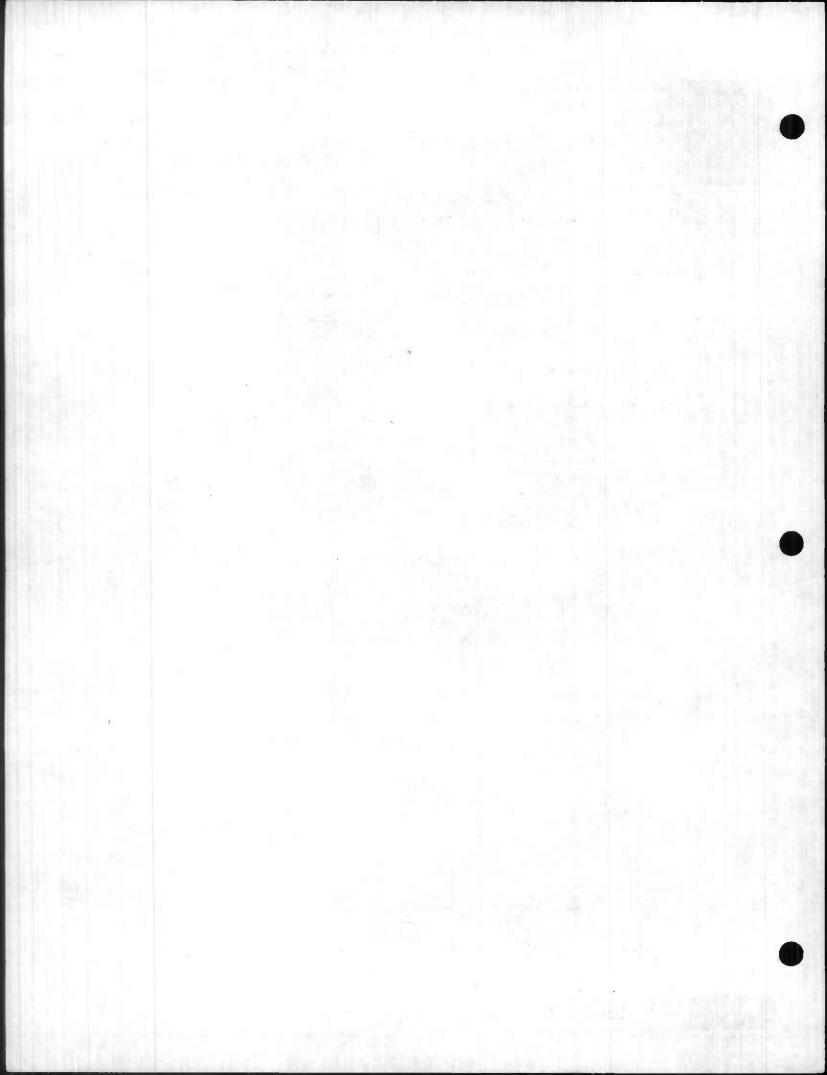
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State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Milton. 23, 2000 Perman December 6:35pm /Medical 4b. City. Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery Hours Min. 8. Dete of Birth (Month, Dey, Year)
May 28, 1915 If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Virginia 6. Sex 1 □ M 2 □ F **Funeral** Months Deys 224-05-1180 85 Yrs. Director Usuel Residence of Decedent 10s Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo Maryland Montgomery Silver Spring r than "natural", or items 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20906 15113 Vantage Hill Road United States Funeral 72 hours sher death 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1940-42 Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐XNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry emit. Pages 1 and 2 should be filled within apartment of Health and Merial Hygione. aportant if hen 27 is marked other than 1 College (1-4or 5+) Elementary/Secondery (0-12) 12 Realtor Real Estate 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Max Perman Sadie Levine 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Florence Perman / Wife 15113 Vantage Hill, Silver Spring, MD 20906 Baltimore, 12/2ate / 00 20c. Location - City or Town, State 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 1 X Burial 2 Cremetion 3 Removel from State ò Falls Church, VA King David Memorial Gardens 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Danzansky Goldberg Memorial Chapel, Inc. 1170 Rockville Pike, Rockville, MD 20852 23a Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, lock, or heart failure. List only one cause on each line. Approximete intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical vasinla Examiner Due to (or es e consequence of) Physician/Medical Examiner attending physicien end for use as the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequenca of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 donknown Fernel Failure 2 24b. Were autopsy findings eveilable prior to completion of cause of death? s certificate hes been si director, page 2 should Completed 24a. Wes an eutopsy 1 Yes 2 No 1 Yes 2 No Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 10 After this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Neturel 5 Pending investigation ours after death. eral Director: Afti filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. edical 29e. Certifier npletely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier D0055-258 10 Vecentea 24, 2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) B. Wilks Rockville Maryland 20852 bell montrose m.D

State Registrar 31. Dete filed (Month Day, Year)

DHMH 16 Rev 6/95

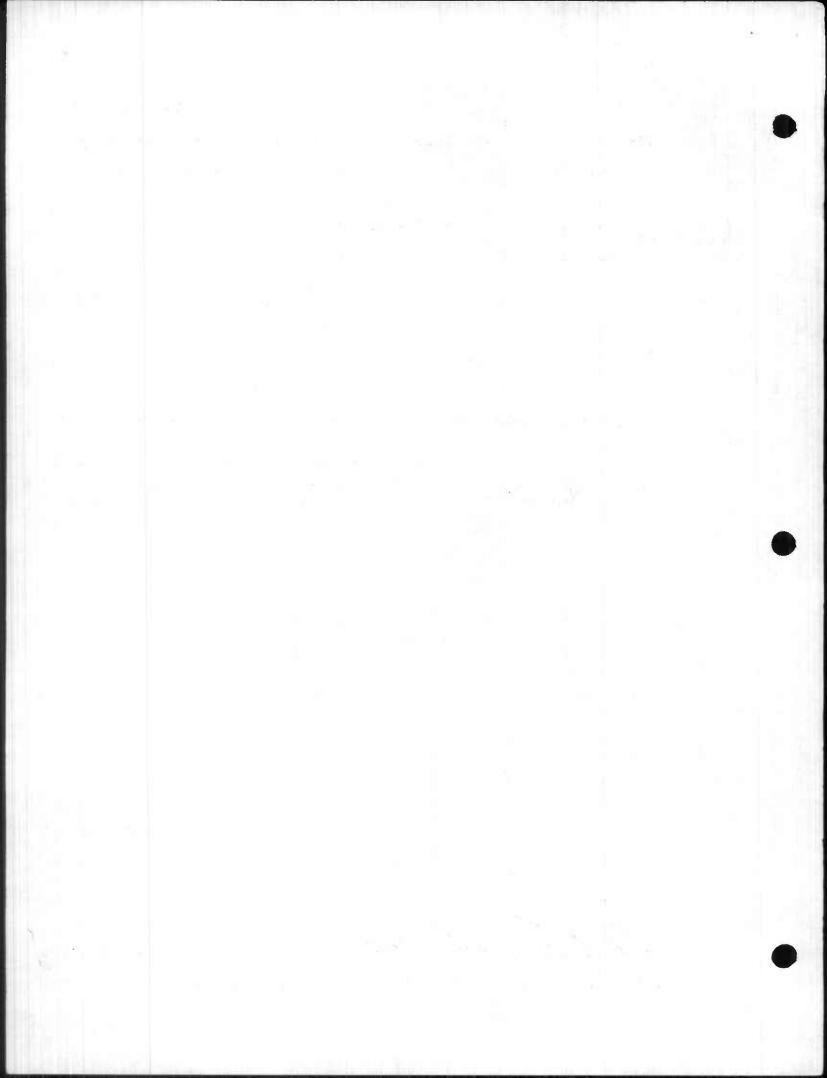
32. Registrer's Signeture



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 2867

					Ce	rtificate	of I	Death	,	Reg. No.	1-5 (	1001	
1		1. Decedant's Nama (First, Middla, La	st)						2. Data of De Month	ath	V	3. Time of Death	
Physic /Medi		Seferino P	erez						12	20 20	Year 000	10;05am	
Exami		4e. Fecility Neme (If not Institution, giv	e street and number,	)			4	lb. City, Town, or L	ocation of Death	4c. County	of Deeth		
		Millennium Re	habiliti	on C	enter	r Silver Spring Montgom					gome	ry	
Funeral Director		267 95 9758	Man alle	ge (In yrs. la 33	st birthday) Yrs.	birthday) If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birth (Month, Day, Year) Co.				9. Birthple Count Cuba	ace (Stata or Foreign ry)		
yand won		Usual Rasidance of Decedant  10e. Stete 10b. County							10d. Insida City Limits				
death with the Mary ms 23e or 23e-f sh cmat be notified.	tor	Md Montgom	erv	Si	lver	Spri	ne					1X□ Yas 2□ No	
4 2 B	Director	10e. Street and Number	•			10f. Zip (				10g. Citizan of \	What Count	ry?	
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P and	by Funeral	11. Meritel Status  1 □ Nevar Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Wes Decedant Armed Forcas  1  Yes 2  If Yas, Giva Yaer or Detes:	?					ck, Whita, a				
15-002 72 hours "natural", idical Ex	ted	15. Decedant's Ed (Spacify only highast gra	ducation		16a. Dece	6a. Decedant's Usual Occ		ation		16b. Kind of B	usiness/Indi	ustry	
Maryland 21215-0020 of 2 should be filed within 72 hours at the and Mental Hygiene. 77 is merited other than "natural, or resumetic event, the Medical Exam	Completed	Elamantary/Secondary (0-12)				(Giva kind of work dona during most of world life. DO NOT usa retired)  Laborer			KIII	Farm	Form		
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arylar should b nd Ments menked umetic e	-	19a. Informant's Neme/Ralationship (	Type, Print)		19b. Maili	ng Addrass (	(Straat	and Number or Ru		er, City or Town,	Stata, Zip	Coda)	
		Mario Matus	(son)		6147	Lees	bur	g Pike	Falls	Church	, Va.	22041	
on 1 and of Healt litem 2		20e. Method of Disposition		20b. Pla	ce of Dispo	nsition (Nema	a of	no.	Data	20c. Location -	City or Tov	vn, Stete	
Page ent of ny or		1 Burial 2 Cramation 3 ☐ 4 Donation 5 Other (Specif							12/22/0	0 Sil	ver	Sring, Md	
Baltimore, permit. Pages 1 a Department of Hes important: If Nem any Injury or othe once.		4 Donation 5 Othar (Specify) Gates Of Heaven 12/22/00 Silver S  21. Signature of Funeral Service Licensee 22. Nema end Address of Fecility Snead Funeral Home & Cremation											
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Physician /Medical Examiner												Intarval Batween Onset and Death	
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68760, ificate be axecuted g physician end as the bunal-transit		Sequentially list conditions, if eny, leeding to immediate cause. Entar Undertying Cause (Disaasa or Injury that initiatad evants rasulting in deeth) Last	C	as a conseq	juanca of):								
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Of Vital Physician: T this certificat ral director, p	To	1 Yas 2 No	Hospital: 1 ☐ Inpati	ent 2 E	R/Outpetier	tpetient 3 DOA	A Othi	ar: ≰⊈tNursing H	ome 5 Resid	ome 5 Residence 8 Other (Specify)		)	
E & 9 5		27. Mannar of Death  ***Matural 5   Pending 2   Accident   Invastigation	28e. Date of Inju (Month, De	ay Year)	28b. Tima o tnjury	f 28	ic. Injun World	yat k? Yas 2 □ No	28d. Describe how injury occurred				
Division  To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicida 6 Could not be datarmined	28a. Place of Injury - At homa, farm, streat, factory, office 28f. Location						28f. Location (: City or Tox	on (Straat and Number or Rural Route Number, Town, Stata)			
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Fo the	Me	29b. Signature and The of certifies	1	/		29c.	Licansa	a number		29d. Date signe	d (Month, D	lay, Year)	
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		30. Name and addrass of person who				Print)						1,2000	
Sta	to	Carlos E. Cov 31. Data filad (Month, Day, Year)	32. Registi	s 812 rer's Signetu		orgia	Av	re.#405	Silver	Sprin	ng, Md	20910	
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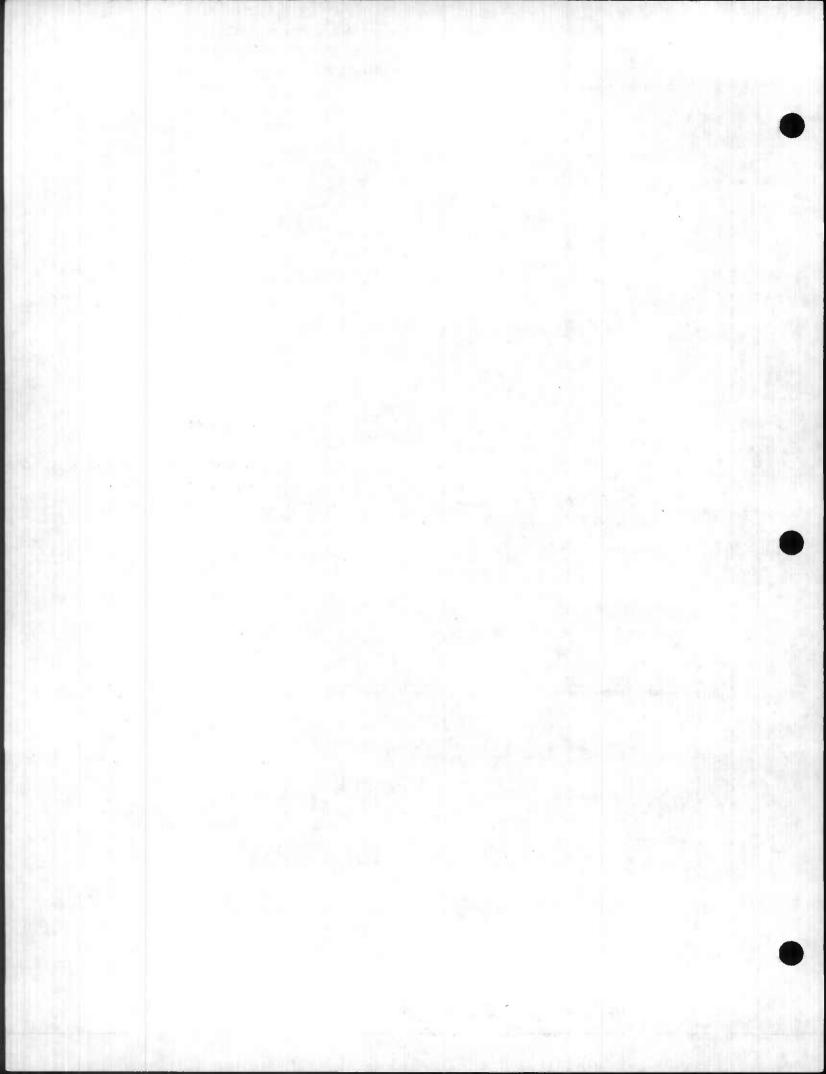
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey Year **Physician** 9:10 PM 2000 December 26, Monica N. Perera /Medical 4b. City. Town, or Location of Death 4a Facility Name (II not institution, give street and number) 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1 M 2 KF Yrs 83 Director 218-27-0490 Dec 28, 1916 Sri-Lanka Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flavra 23a or 25a-f show the Medical Examiner must be notified at the Maryla 1 Yes 2 No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13908 Bauer Court 20853 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes, 2∑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Meritel Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: à 34 Widowed 4 □ Divorced Asian Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filled within Elementery/Secondary (0-12) College (1-4or 5+) I Hygis other Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Mental marked Stansilaus Holsinger Muriel Diaz 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 at Department of Health an Important: If New 27 is n Marcus Perera/Son 1124 Parrish Dr, Rockville, MD 20851 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Pages 1 1 Burial 2 XCremation 3 Removel from State ò 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 12/28/00 Alexandria, VA 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licenses delly aw 500 University Blvd., W, Silver Spring, MD 20901 23. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CZREIOVZSEVIZR Examiner Due to (or as a consequence of): Physician/Medical Examiner Acute Myoczk the ettending physician and shed for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or as e consequence of) Due to (or es e consequence of): The law requires that the death 23b. Did tobacco use contribute to the cause of death? this certificate has been signed by the rail director, paga 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No Division of VItal funeral director, 25. Was case referred to medical 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred is or Attending Partial after death.

I Director: After to in by the funera 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Cartifier Medical 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number Wille of re Mo-1310 27 Dec 2000 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) William F. Runge ms 31. Date filed (Month, Day, Year) DEC 2 9 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95



**Physician** /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

**Examiner** 

Director

Funeral

by

Completed

10

**Funeral** 

**Director** 

ind Mental Hygiene.

Additional Hygiene.

Transcad other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than "natural".

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1 and 2 should be filed within 72 hours after death

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of Health Item 27

Pages 1

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

or Attending Physician:

24 hours after Funeral Directions of Funeral after

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Examin Physician/Medicai by Completed Be 10 Certification:

edicai

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Sevatural 2 Accident 3 ☐ Suicide

4 C Homicide

29a. Certifier (Check only one) 5 Pending investigation

28a. Date of Injury (Month, Dey Year) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. fnjury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

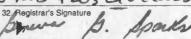
29d. Date signed (Month, Dey, Year) DECEMBER 18 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

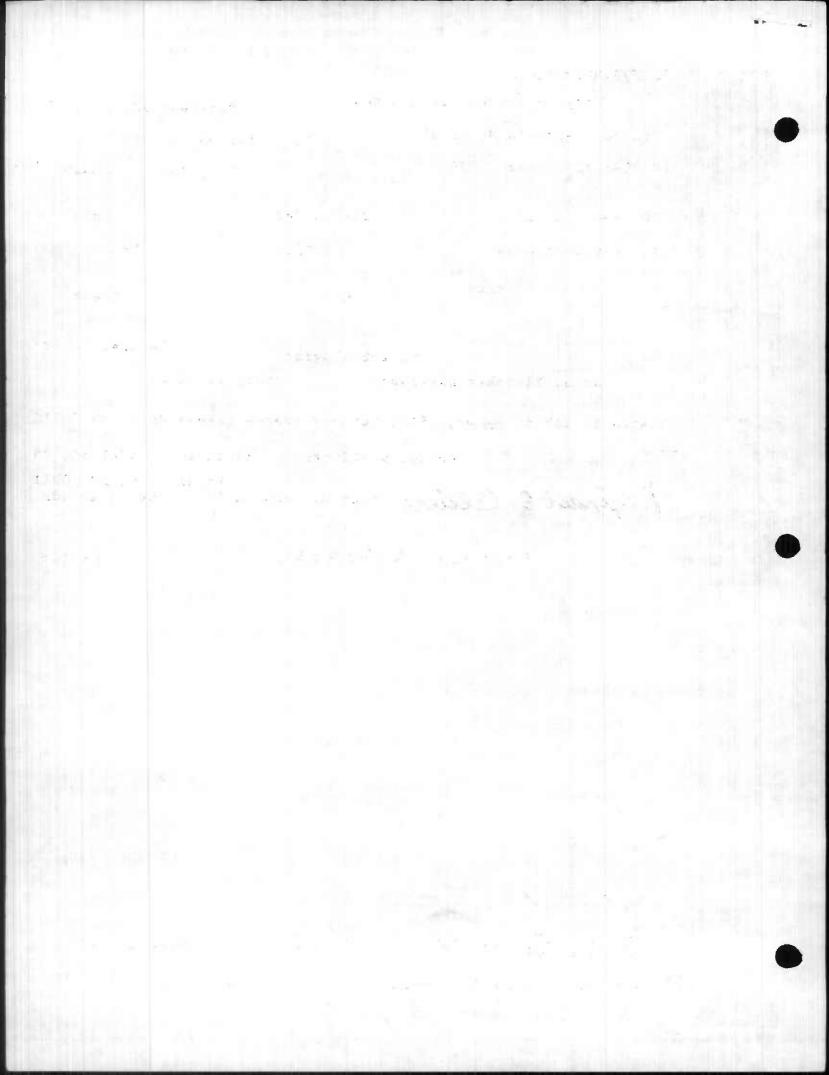
DEVURE MD 4203 QUEENSSORY Rd H44TTSVILLE MD 20781 31. Date filed (Month, Dey, Year)

State Registra

DEC 28 2000



**DHMH 16 Rev 6/95** 



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Olivia Payne December 21, 2000 2:50 am /Medical 4a Facility Name (ff not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice- Casey House Rockville Montgomery H Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (fn yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days Hours 10 M 2 F Months Yrs. 57 215-02-8980 Director Jun 8. Barbados Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Heelth and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show way injury or other treumatic event, the Medical Examina must be notified at once. 10b. County 10c. City, Town or Location 1 Yes 2 No Directo Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2205 Shorefield Road #824 20902 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baitimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurse Medical 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 8 Avis Maloney Prince Albert Payne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Denise Michelle Payne/ Daughter 812 University Blvd., E #6, Silver Spring, MD 20903

20a Method of Disposition (Neme of Date Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 1 ☐ Burial 2 ※ Cremation 3 ☐ Removal Irom State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 12/28/00 Alexandria, VA 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licensee 500 University Blvd., W, Silver Spring, MD 20901 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart lailure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical tmmediate Ceuse (Finel disease or condition resulting in deeth) 5 months a Primary Amyloidosis Examiner Due to (or as a consequence oi): Examiner that the death certificate be axecuted physicien end s the burial-transit Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 88 for use as 980 P.O. signed by the a Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records. þ requires 24b. Were autopsy tindings available prior to should I 24a. Wes an autopsy performed? Completed completion of cause of death? The law i certificete hes b 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 CMOther (Specify) Hospice 10 this After this 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28c. fnjury at Work? 28b. Time of Certification: or Attending 1X Netural 5 Pending investigation 1 Yes 2 No deeth. Director: / 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di completely filled is 1 CX Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner es steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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State

Registra

E.P. Libre, MD

31. Date liled (DECDa2 Y91) 2000

32 Registrar's Signature

MD

30. Nama and addrass of person who completed ceuse of death (Item 23a) (Type, Print)

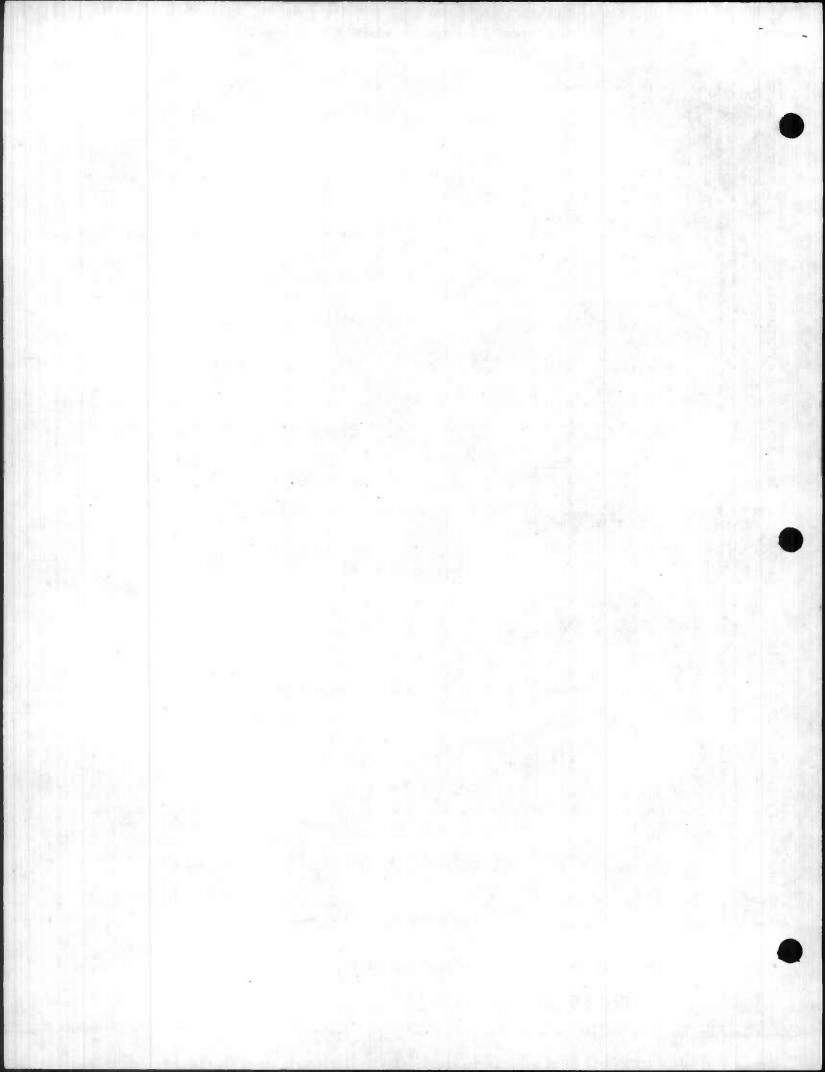
10400 Connecticut Ave., Kensington, MD ocula

D 09470

December 21, 2000

20895

**DHMH 16 Rev 6/95** 



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Yee **Physician** 1640 MABLE OUICKER Decenter 21 2000 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner - Washing too Gasport Court rivce 8. Date of Birth (Month, Dey, Year) If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 1□M 2/□F 227-30-6079 Yrs. North Carolina Director MAR. 8, 1907 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or itema 23a or 28a-f ahow the Medical Examiner must be notified at PRINCE GEORGES 1X Yes 2 No FT. WASHINGTON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 2911 GASPORT COURT 20744 Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Biack, White, etc. 11. Maritel Stetus permit. Peges 1 and 2 should be filed within 72 hours effect. Department of Health and Mental Hygiene, important: If Item 27 le marked other than "natural", or then page. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: AFRO-AMERICAN à 3 Widowed 4 □ Divorced Completed Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) NONE NONE N/A 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be DAN CROSBY CAROLINE CROSBY P 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1923 BELL HAVEN DR., LANDOVER, MD 20785 WILAMEINA MBUGUA / DAUGHTER 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Sfete DEC. 26, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete RIVERDALE PARK CREMTORY RIVERDALE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 2000 21. Signeture of Furjeral Service Lice 22 Name and Address of Facility DUDLEY FUNERAL HOME Lower MT. RAINIER, MD 20712 3200 RHODE ISLAND AVE., 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete fntervel Between Onset and Deeth **Physician** /Medical Cardiovas en a Pis case tmmediate Cause (Finel disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by The law requires 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Wes an autopsy Completed has 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vitai 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) To Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA ¥ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Division or Attanding 5 Pending investigation 1- Netural r death. 1 Yes 2 No To the Hospital or Attandi within 24 hours after death To the Funeral Director: A completely filled in by the f 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Roule Number, City or Town, Stete) 3 ☐ Suicide 28e. Pfece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end piece, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one)

State Registrar

29b. Signeture end title of certifier

31. Date filed (Month, Pay, Year)
DEC 2 8

Salvador

Do

3001

32. Registrar's Signeture

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

VS7

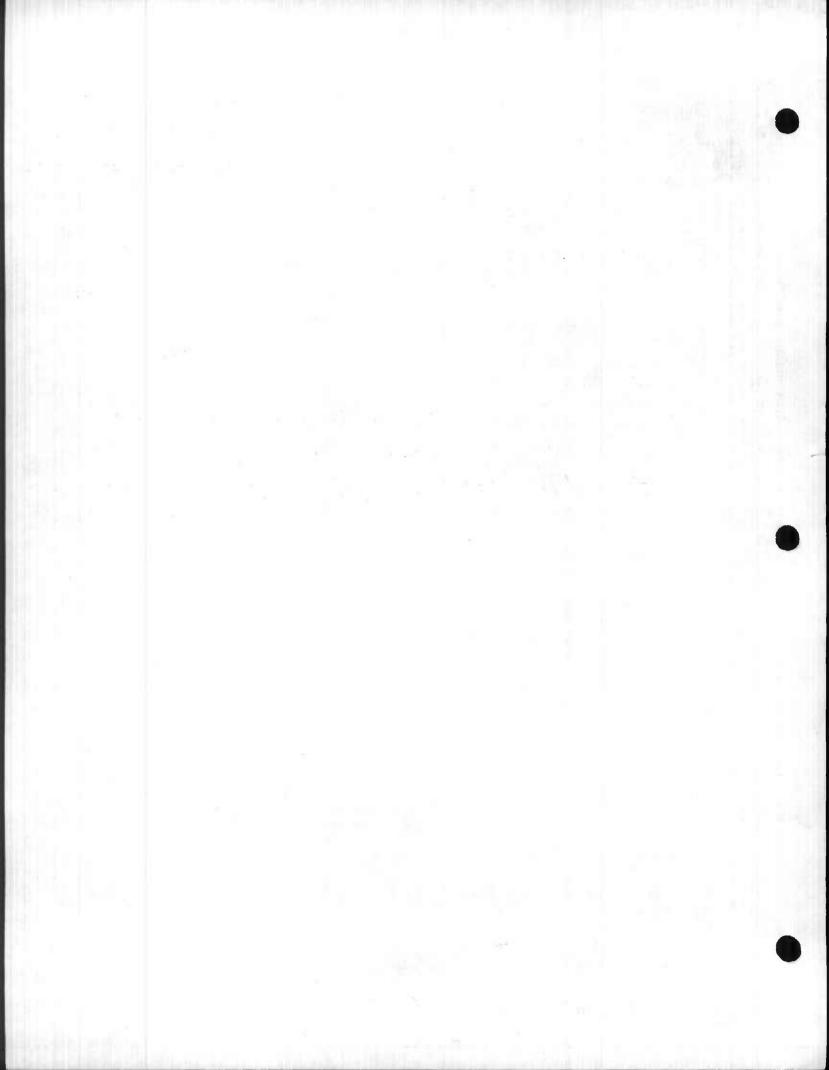
29c. License number

HOOS3 927

Hospital Drive Chevely

29d. Date signed (Month, Dey, Year)

MARY / AND 20783



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#2,3 perPHYG791 1/9/2001 EW 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Yaar 0600 6AM 2000 Katch ford Voge SON hiAd -Nov. 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) PRINC Regional HOSPITAL saurel Jaur seorge If Under 1 Year | If Under 24 Hrs. 6. Date of Birth (Month, Day, Ye Nov. 14, Birthpiece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Year) 2000 Days Months 1 □ M 2 ₩ F Vre none Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD P.G. Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5902 51st Ave #402 20780 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedant Ever in U.S. Armed Forces? Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) none 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Ralph Vogelson Jasmine Ratchford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 5902 51st Ave #402 Hyattsville, MD 20780 Jasmine Ratchford - Mother 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 1/7/00 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Metropolitan Funeral Svc. 5517 Vine St. Alexandria, VA 22310 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset end Death fmmediate Cause (Final disease or condition resulting in death) EXTreme Prematurity Due to (or as a consequence of): Placental abruption Due to (or as a consequenca of). anoma Major Cerebral Dua to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yas 2 No 25 Was case referred to medical 26. Place of Death (Check only one) (y)

**Physician** /Medical Examiner

attending physicien and for use as the burial-tran

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Director: /

To the Hospital within 24 hours a To the Funeral Completely filled

or Attending Physician: after deeth.

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The law requires that the deeth certificate be executed

Division of Vital Records, P.O. Box 68760.

Physician/Medical Examiner

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Certification:

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**Physician** 

**Funeral** 

Director

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Baltimore, Maryland 21215-0036

should be

Pages 1 and 2

of Health Nem 27

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/Medical

Director

Funeral

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Completed

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury resulting in death) Last

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

		Ec. I lace of Death Control										
examiner?	No	Hospital: 1 Mnpatiant 2	☐ ER/Outpatient	3□	DOA Other: 4	□ Nursing H	doma 5 ☐ Residence 6 ☐ Other (Specify)					
7. Manner of Deeth 1 D Netural 2 Accident	5 Pending invastigation		28b. Time of Injury	М	28c. Injury at Work?	2 🗆 No	28d. Describe how injury occurred					
3 ☐ Suicide	6 Could not be determined	28e. Plece of Injury - At	home, ferm, stree	t, fect	tory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)					

29a Cartifier

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end pleca, and due to the ceuse(s) end manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, dete end pleca, and due to the ceuse(s) end manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, dete end pleca, and due to the ceuse(s) end manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

U.D.

30. Nama and address of person who completed cause of d ath (Item 23a) (Type, Print)

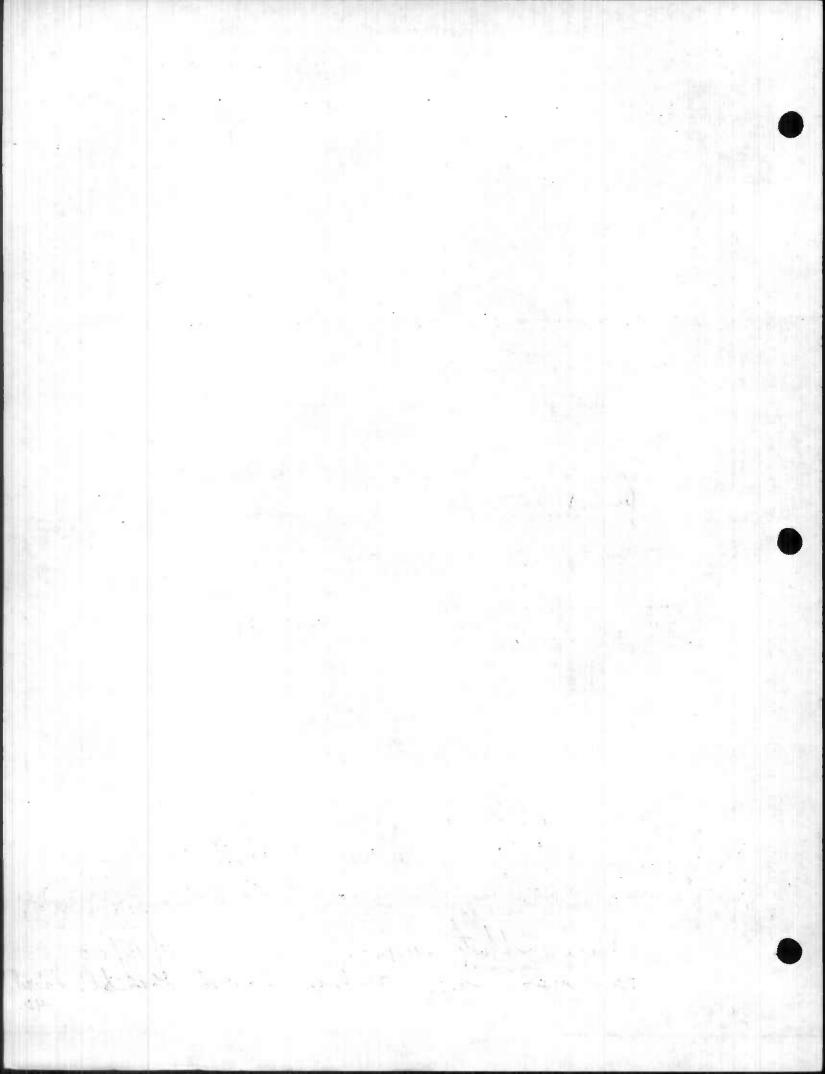
4.

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signatura

ORIGINAL

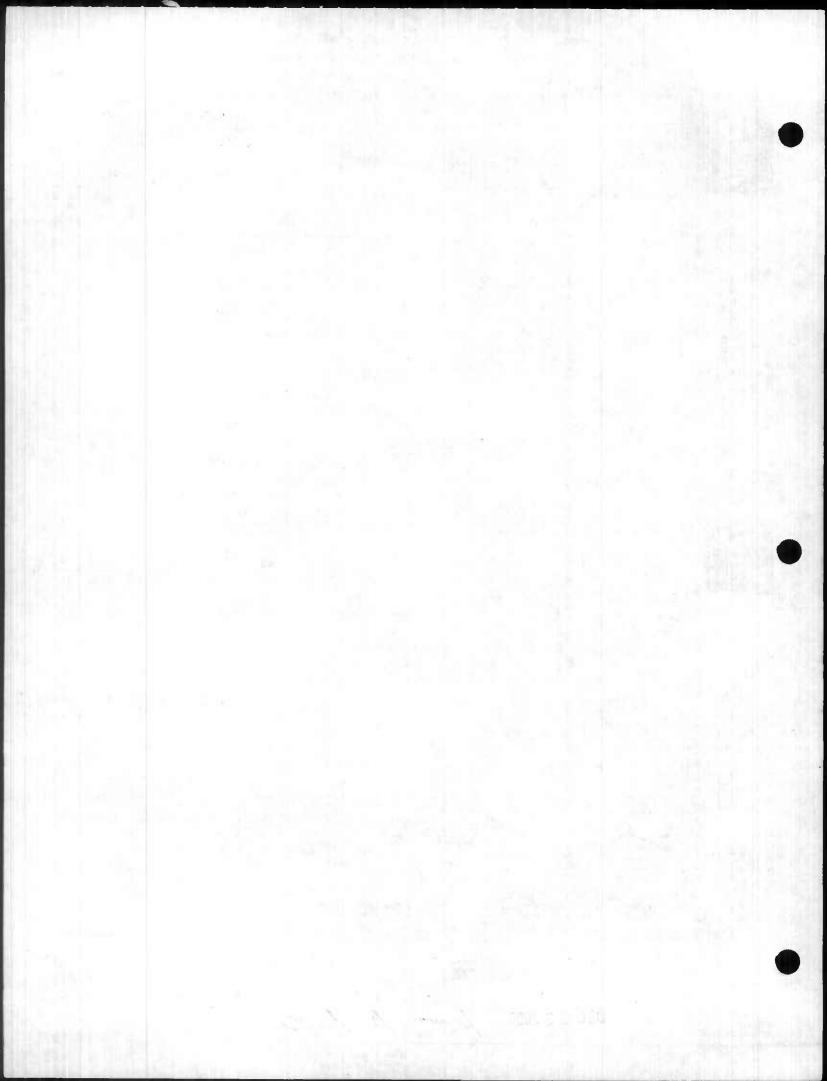
DHMH 16 Rev 6/95



Amended #9, 2RD 12/0

ysician		a perPHYG795 5/14/2001 EW Certificate of Death  1. Decedent's Nama (First, Middla, Last)							2. Data of Deat		3. Tima of Death	
Medical	EDWARD VICTOR ROBEY							Month DECEMBI	ER 25,	2000 19:32 P.		
aminer		Name (If not insti ACRED H						4b. City, Town, or Lo		of Death EGANY		
neral ector	219-8	2-7245		M 2□ F	Aga (In yrs. 2'	last birthday) 7 Yrs.	If Under 1 Yaa Months Days	r If Undar 24 Hrs. s Hours Min.	8. Data of Birth (Month, Day) JUNE 27	,1973 (	9. Birthplaca (Stata or Foraig Country) CUMBE MD	
Inermant be nutfled at	Usual Rasidence of Decedant  10a. State 10b. County 10c. City, Town or Location  MD ALLEGANY CUMBERLAND								10d. Insida City Limits 1 🌣 Yes 2 🗆 No			
be nutried Director	10e. Street	10e. Street and Number 10f. Zlp Coda							1	/hat Country?		
ral	761	761 CLEVELAND AVENUE 21502								U.S.A		
by I	17 Ne	11. Marital Status  1 1 Nevar Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U. Armed Forces?  1 ☐ Yas 2 1 No If Yas, Giva Yaar or Dates:					Vas Decedent of f Yas, specify Cu I□ Yas 2X No	Hispanic Origin? (Spe ban, Maxicen, Puerto I Specify:	ocify Yes or No- Rican, atc.)	Black	e - Amarican Indian, k, Whita, atc. : WHITE	
eted		15. Decedant's Education (Specify only highast grada complated)					lant's Usual Occi	a during most of working	16b. KInd of Business/Industry			
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Be	1115	7. Father's Nama (First, Middle, Last)  EDWARD WILLIAM ROBEY						18. Mother's Nama			6)	
To						10h Mailin	KATHLEEN RITA WILEY  b. Mailing Addrass (Street and Number or Rural Routa Number, City or					
		eant's Name/Rele EEN R. V			2			ROAD, CUM			1502	
		d of Disposition	121111	, 181111	20b.	Place of Dispo	sition (Nama of		-	20c. Location - City or Town, Stata		
	202. Martido of Disposition    Donation   Do									LAND, MD		
2												
Suc	1	mud.	A	Inh.	101			FUNERAL H			1502	
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E E	Sequentially list conditions, if any, feeding to immadiate causa. Enter Undarlying Ceuse (Disease or injury c.											
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67	Part II. Oth	Part fl. <b>Other significant conditions</b> contributing to death but not rasulting in tha undarlying causa given in Part l						great in Fart I.			3 Probably 4 Unknow	
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Completed by	25. Was ca examin 1 🗌 Ya	er?	-	1 inpa	27. Manner Death  1 Naturel 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Tima of Injury 4 Work?  2 Accident investigation 28d. Describe how injury 4 Work?  1 Yas 2 No							
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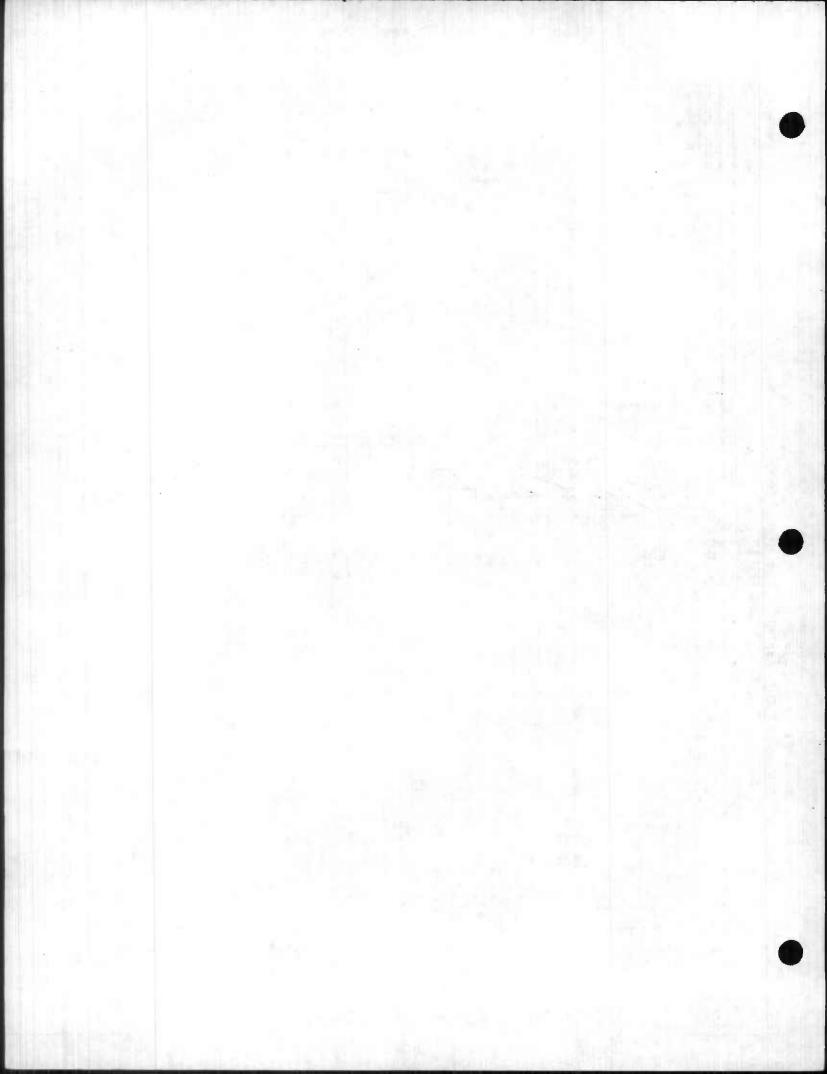
DHMH 16 Rev 6/95



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

1.1	Decedent'a Name (First, Middle				rtificate of			g. No:	1: 2 9 7 3. Time o	of Death		
cian lical	EMORY Facility Nama (If not institution	FRANK		RO	SENBERG:	ER 4b. City, Town, or Lo		er 23.20	00 034	0 a.m		
iner 48	SACRED HEAR					CUMBER	LAND	ALLEG				
2	Social Security Number 13-20-2913	6. Sex 1 M 2 □ F	7. Aga (In yrs. 76	last birthday) Yrs.	If Under 1 Yeer Months Days	If Under 24 Hra. Hours Min.	8. Data of Birth (Month, Day, APRIL 1	Year) 8 1924	Birthplace (Stete Country) MARYLAND	or Foreign		
	a. State 10b. County		10c. Ci	ity, Town or Lo	ocation							
M co	MARYLAND ALLEGANY FROSTBURG								1 Yes	s 2/1 No		
Funeral Director	Street and Number     18218 BORDEN	VADD BOAD	N W		10f. Zip Code	.532	10	_				
11.	. Marital Status 1 ☐ Never Merried 2 ☒ Marri	12. Was Dece Amed For 1 X Yes If Yes, Giv	dant Evar in Urces?			dispanic Origin? (Span, Mexican, Puarto	ecify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc.			
	3 Widowed 4 Divorced  15. Decedent (Specify only highes Elementery/Secondary (0-12)	Yaar or Da a Education t grada completed)		16a. Dece (Give life.	DO NOT use retire	during most of work	ing		intizen of What Country?  U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: WHITE  Kind of Business/Industry  TRUCKING COMPAN  In Sumeme)  LARUE  FOR TOWN, Stefe, Zip Code)  DSTBURG, MD 21.53  Location - City or Town, State  FROSTBURG, MARY  RAL HOME P.A.  ARYLAND 21.532  Approximate to the cause of the country of the c			
17	8 Father's Nama (First, Middle, I	()			DRIVER	18 Mother's Nem	e (First Middle A	The r 23.2000 0340 and representation of the results of the result				
	JOHN		ROSENB	ERGER		GRACE	- () 7					
	a. Informant's Name/Relationsh		City or Town, St	ete, Zip Code)								
	DONNA ROSENBER	RGER / WIF				YARD ROA				32		
200	a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp.		Stata	cematery, cra	osition (Neme of metory or other ple G MEMORIA		EC27,200			YLAND		
21	21. Signature of Funaral Service Licens 22. Nama and Addrass of Facility  DURST FUNERAL HOME P.  57 FROST AVENUE FROSTBURG, MARYLAND 215											
23												
Im	Immediate Couse (Final disease or condition Colon Cancer 240											
	Due to (or es a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying.											
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2 Les	sulting in death) Last	d	Dua to (d	or es a consec	quance of):							
Pa	rt tl. Other eignificant conditio	ne contributing to de	ath but not res	sulting In the u	inderlying cause gi	ven in Part I.	23b. Did to	bacco use contr	ibute to the cause	of death?		
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5							1 □ Ye	s 2 10	1 ☐ Yes 20	□No		
	. Wes case referred to medical examiner?	Hospital:	/		nt 3 DOA Ot	her	th (Check only on					
OF 27.	1 Yes 2 No  Menner of Deeth 1 Natural 5 Pending 2 Accident Investig	28a. Date of	28a. Date of Injury (Month, Dey Year)  28b. Time of Injury Injury			4 ☐ Nursing Hory at rk?						
ertitica	3 Suicide 6 Could n 4 Homicide determi	ned 200. Place	M 1 ☐ Yes 2 ☐ No  Place of Injury - At home, farm, street, factory, office uilding, etc. (Specify)  28f. Location (Street end Number or Rural Ro City or Town, Stete)						or Rural Routa Nu	mber,		
Medicai Certification:			sis of exemine							n(s)		
29	b. Signatura and title of certifier	11			29c. Lican	sa number	2	9d. Date signed	(Month, Day, Year)			
	Jo lin				230	0766		Decemb	er 27-20	00		
V	Name and address of person of Krama Hyd.  Date filed (Month, Dey, Year)  DEC 2 9	Hoonai	e of deeth (Item	9244	print) Seton Dr.	ive Cun	berlan	d MD	21500	2		

DHMH 16 Rev 6/95

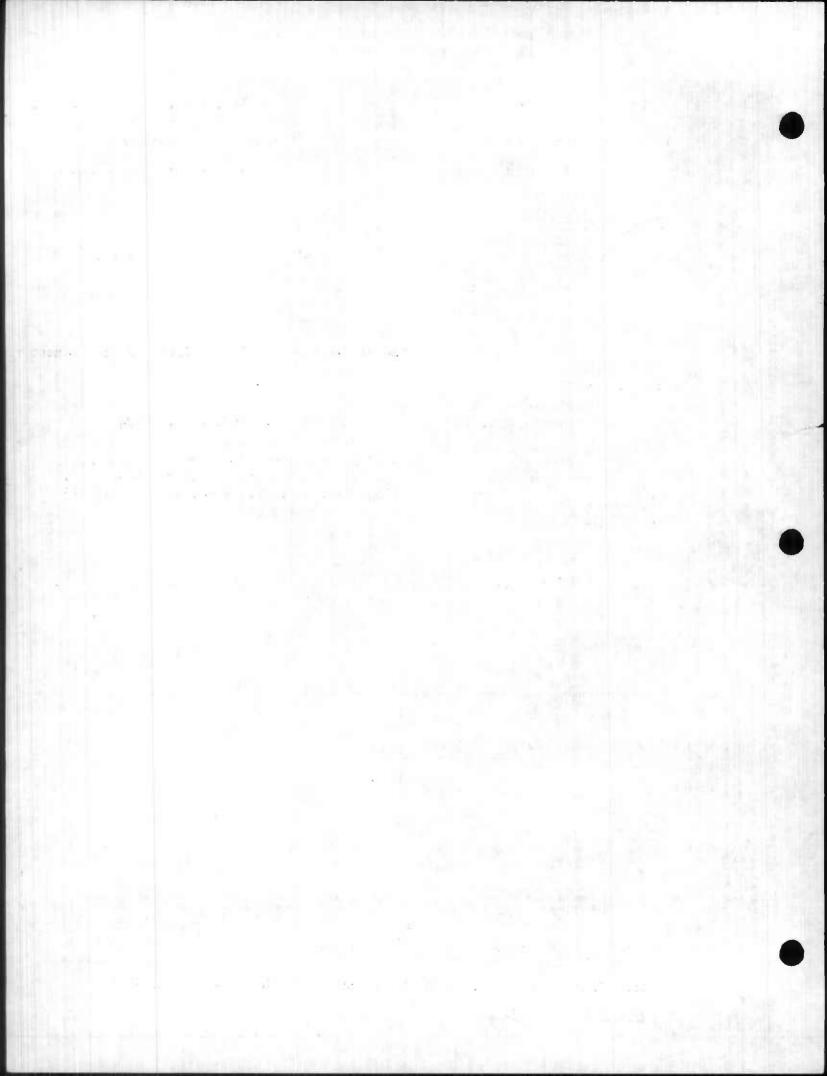


## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 42875

			Certificate of	Death	Reg. No.	42013				
	1. Decedent's Name (First, Middle, L	est)	TISTED ST	2. D	ate of Death	3. Time of Death				
Physician /Medical	Helene Luve	Rowe		Dec	ate of Death fonth 24, 2000	6:25 AM.				
Examiner	4a Facility Name (If not institution, gi	ve street end number)	the state of	4b. City, Town, or Location	n of Death 4c. Count	of Death				
	4968 Allan Road	En Walt Street All		Bethesda		omery				
Funeral Director	5. Social Security Number 6. 579-58-2376  Usual Residence of Decedent	Sex 7. Age (In yrs. ie	Yrs. If Under 1 Yea Months Days	r If Under 24 Hrs. 8. 0 Hours Min. //	ete of Birth Nonth, Day, Year) 1. 11, 1905	9. Birthplace (State or Foreign Country) Washington, DC.				
B a sa	10a. State 10b. County	10c. City	, Town or Location			10d. Inside City Limits				
or 28s-f sh be notified.	Maryland Montgomery Bethesda  10e. Street and Number 10g. Citizen of What Co									
				20816	υ	.S.A.				
Maryland 21215-0036  2 should be filed within 72 hours after death in and Mental Hygiens. The marked other than "netural", or learns 23 treumetic event, the Medical Examiner must treumetic event, the Medical Examiner must To Be Completed by Funeral	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:	<ol> <li>13. Was Decedent of If Yes, specify Cu</li> <li>1 ☐ Yes 2 X No.</li> </ol>	ce - American Indian, ck, White, etc. y: White						
nd 21215-0 be filed within 72 ho tel Hygens d other than 'netur event, the Medical. Be Completed	15. Decedent's E (Specify only highest gi	ducation rade completed)	16a. Decedent's Usual Occu	upation a during most of working ad)	16b. Kind of B	usiness/Industry				
To see and I	Elementary/Secondery (0-12)	College (1-4or 5+)			D 111	4 0 1 1 71				
Co Hard	17. Father's Name (First, Middle, Las	4	School Tead		Public School Educat Name (First, Middle, Maiden Sumame)					
Be seed to be seed to		a Lee	nej							
Tould Mend	19a. Informant's Name/Relationship	(Type Print)	19b. Mailing Address (Stree			State Zin Code				
Mary Services										
Sattimore, emit. Pages 1 an epartment of Heal reportant if New 2 ny Injury or other fice.	Mary Anne Ritenour - Dau. In Law 262 Marganza South, Laurel, Md. 20724  20a. Method of Disposition  20b. Place of Disposition (Neme of cemetery, crematory or other place)  20b. Place of Disposition (Neme of cemetery, crematory or other place)  20c. Location - City of cemetery, crematory or other place)									
The state of	4 Donation 5 Other (Specify) Cedar Hill Cemetery 2000 Suitland, Me 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons,									
B Coppe	Naman A	Washington, D.C. 20016								
Physician /Medical	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the deeth one cause on each line.  Inanition	. Do not enter the mode of dy	ring, such as cardiac or res	piratory arrest,	Approximate Intervat Between Onsef and Deeth  Months				
Examiner	resulting in death)  Due to (or as a consequenca of):									
2 5		Years								
be executed lician and buriel-transit at Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequenca of):							
687 licate	resulting in death) Lest	Due to (or	as a consequence of):		23b. Did tobacco use contribute to the cause of death					
death death	Part II. Other significant conditions	contributing to death but not resul	Iting in the underlying cause g	iven in Part I.						
is, P.O. Box is that the death certigned by the attending be detached for use a by Physician/M	Hypertension		3 Probably 4 Unknown							
Cords requires should be		Atheriosclerosi	S		24a. Was an autopsy performed?	24b. Were autopsy findings evailable prior to completion of cause of death?				
C = -8 5					1 ☐ Yes 2 ₺ No	1 ☐ Yes 2 ☐ No				
Vital I	25. Was case referred to medicat			26. Placa of Death (Ch						
Of Vita Physician: this certific ral director. To Be	examiner? 1 ☐ Yes 2 💆 No	Hospitat: 1   Impatient 2   E	R/Outpatient 3□ DOA	at	5 Residence 6 □Ot	her (Specify)				
nding eth. r: After re fune	27. Manner of Deeth  1 X Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year)	28a. Dete of Injury (Month, Day Year)  28b. Time of lnjury et Work?  28d. Describe how injury occurred Work?							
DIVIS	3 Suicide 6 Could not determined	28e. Plece of Injury - At hor building, etc. (Specify)	me, farm, street, fectory, office	28f. L	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Division of To the Hospital or Attending P Within 24 hours after deeth. To the Funeral Director: Affect completely filled in by the funeral Medical Certification:		hysician: To the best of my know miner: On the basis of examinati and manger steted.								
To the Vithin County Complex	29b. Signeture and title of certifier	12	29c. Licer	nse number		ed (Month, Day, Year)				
25	1 DONY	2	D-39	456	December	26, 2000				
60	30. Name and address of person who		23a) (Type, Print)  O Wisc. Ave.	#930. Cherry	Chase, Md. 3	20815				
	Lila T. McCo  31. Dete filed (Month, Dey, Year)	nnell, FD. 555		"JJU, OHEVY	onase, na. z	.00,2				
State Registrar	DEC 2 9 2000		9. Sports							

DHMH 16 Rev 6/95



## Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** December 24, 2000 Noel Francis Rossini 21:55 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. Birthplace (State or Foreign Country)
 LA 8. Dete of Birth (Month, Dey, Year **Funeral** Months Days 12 M 2 F 49 Oct. 10,1951 434-13-6038 Director Usual Residence of Decedent with the Meryland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 23a or 28a-f show the Medical Exerciner nust be notified at Maryland Montgomery Gaithersburg 1 TYes 2 KNo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16704 Shea Lane 20877 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yea or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 11. Meritel Stetus 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 Never Married 2 ☐ Married Maryland 21215-0020 1 Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be nent of Health and Mental ant: If Itam 27 is marked o Elma Truxillo Noel Raymond Rossini 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important: If Item 27 le any injury or other trea 000.0. Mr. James Michael Rossini(Brother) 16704 Shea La.-Gaithersburg, Maryland 20877 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 12/29/00 Rockville , Maryland Parklawn Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr.-Gaithersburg, MD20877 elelia 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical A 19 CAUVOST A **Examiner** Due to (or as e consequence of) Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the bunel-tren Due to (or as a consequence of) Box 68760. Due to (or as a consequence of) P.O. deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sate has been signed by page 2 should be detec 1 ☐ Yss 2 No 3 Probably 4 Unknown of Vital Records, by 24a. Was an autopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of death? Be Completed this certificate has 1 Yes No 1 Yes 2 No or Attending Physicien: after death.

Director: After this certific d in by the funeral director, 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 → Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 201No Certification: To 28c. Injury et Work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending Injury 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide To the Hospital within 24 hours a To the Funerel D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) Medical 29e. Certifier (Check only one) end manner steted. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 12-25-2000 451280 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) Dr. Anushiravan Dadgar, M.D.-13219 Executive Park Terr.-Germantown, MD. 20874

DHMH 16 Rsv 6/95

State

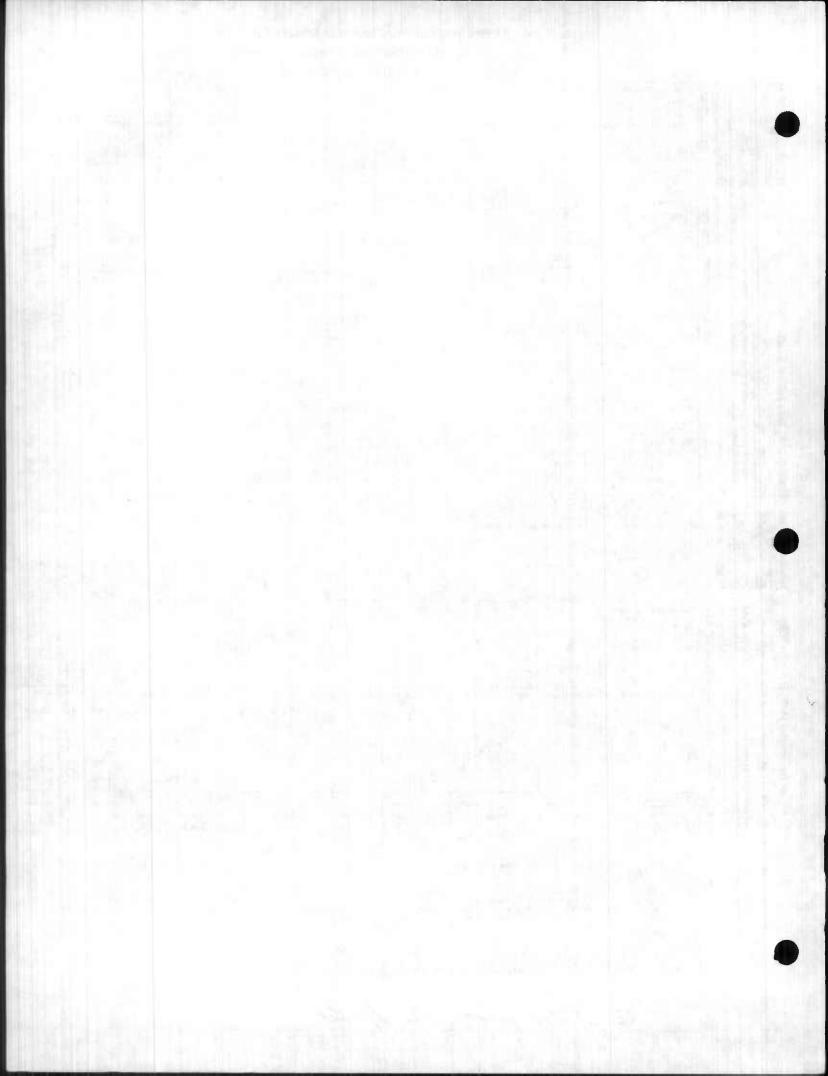
Registrar

31. Dete filed (Month, Dey, Year)

DEC 2 7 2000

32. Degistrer's Signature

Frence



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** SIDNEY DEC. 24 2000 7:25 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street end number) Examiner HCR MANOR CARE POTOMAC **POTOMAC** MONTGOMERY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Sociel Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Director 578-05-1355 92 SEPT.21,1908 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 14 Yes 2□ No 25a-f Directo MD MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 5512 THORNBUSH COURT 20814 U.S.A. Funeral then "natural", or items. The Medical Examiner mu 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Merital Stetus Bleck, White, etc. 1 Never Merried 2 Merried Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: py 3X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filled within Elementary/Secondary (0-12) College (1-4or 5+) Hygiene FURNITURE STORE OWNER 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Pages 1 and 2 should be fin ment of Health and Mental H lant: If item 27 is marked oth jury or other traumetic even Be NATHAN ROSE UNKNOWN 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) RICHARD ROSE/SON 5512 THORNBUSH COURT, BETHESDA, MD 20814 Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete JUDEAN MEMORIAL GARDENS 1 Burial 2 Cremetion 3 Removel from Stete 12/26 OLNEY, MD 4 ☐ Donetion 5 ☐ Other (Specify) 2000 21. Signeture of Funeral Service Licansee 22. Name end Address of Fecility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 23a Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Approximete Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical a RESPIRATORY FAILURE Examiner Due to (or es e consequenca of): Examiner CONGESTIVE HEART FAILURE ettending physician end for use as the buriei-transit the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in death) Last Due to (or es e consequence of) PROSTATE CANCER Box 68760 Physician/Medical Due to (or as e consequence of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed certificate hes b firector, page 2 st The law 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Deeth (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Neturel or Attending 5 Pending Investigation s efter death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 4 ☐ Homicide .= To the Hospital o within 24 hours of To the Funeral Di completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or Investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 12-25-2000 naum 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

State Registrar

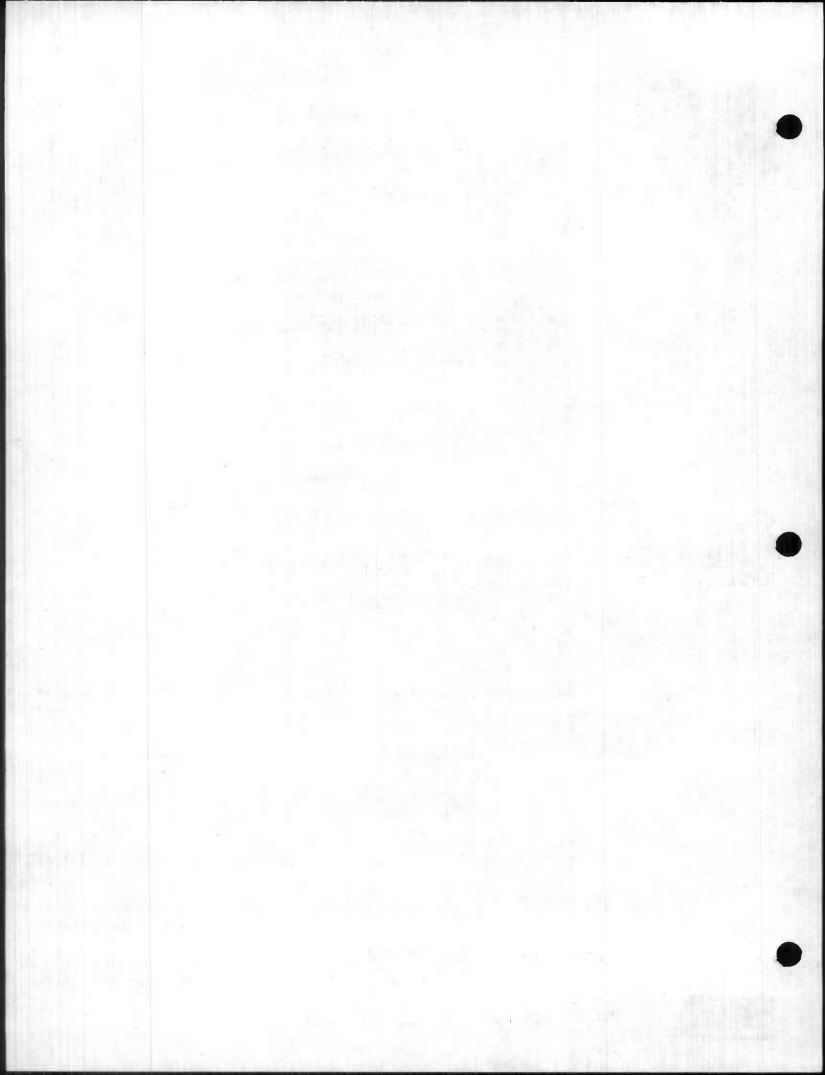
**DHMH 16 Rev 6/95** 

31. Date filed (Month, Dey, Year)

DEC 27 2000 32. Registrer's Signeture

**ORIGINAL** 

SHARON A. SCANLON M.D. 5530 WISCONSIN AVENUE #930 CHEVY CHASE, MD 20815



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #23 Pt1&2,12/28/2000, BMW, Montg.Co. 2. Data of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Dey **Physician** Virginia Belle Reveal December 24, 2000 11:50 am /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Nama (If not institution, giva street and number) **Examiner** Suburban Hospital Bethesda If Under 24 Hrs Montgomery If Under 1 Year 8. Dete of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Deys Hours 1 M 2 F Yrs. 89 Director 309-22-3342 May 11, 1911 Indiana Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at 1 ☐ Yes ¾XNo Directo Maryland | Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 321 University Blvd., W #325 USA Funeral 20901 12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, White, etc. filed within 72 hours after 1 Never Merried 2 ☐ Merried 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Laboratory Technician NIH Maryland 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental ant: If Item 27 is marked or of Health and Ments I Item 27 is marked r other traumatic e 2 Carl A. Reveal Ethel L. Messick 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen M. Henson/Executor of Will 709 Webster Street, New Orleans, LA Baltimore, 20b. Plece of Disposition (Neme of cametery, crematory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition Dete Burial 2 Cremetion 3 Removal from State Injury or permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 12/29/00 Silver Spring, MD 21. Signature of Fynaral Servica Licensee 22. Neme and Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximete tntervel Between Onset and Death **Physician** RESPIRATORY FAILURE Immediate Ceuse (Finel disaese or condition resulting in death) /Medical Examiner Severe Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es a consequença of) Congestive Heart Failure Physician/Medical Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? HRONIC OBSTRUCT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were eutopsy tindings evailable prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? 1 Yas 2 No 1 Yes 2 No Be 25. Wes case referred to medical examinar? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. tnjury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1-Maturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 16 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated. ro the h within 24 h To the Fune 29d. Dete signad (Month, Day, Year) 29c. Licanse numbar 29b. Signature and title of con

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

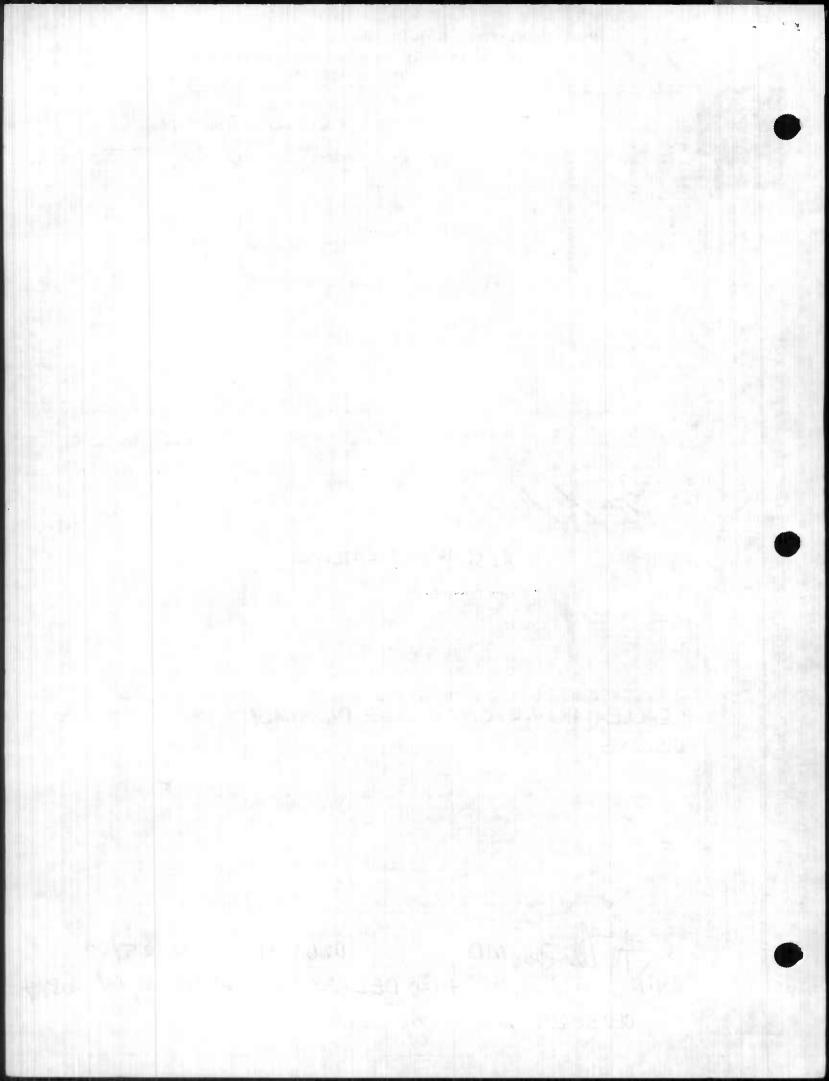
**DEC 28** 

2000

32. Begistrar's Signature

assion person who completed cause of death (Item 23e) (Type, Print).

GMIZUS, MO 4930 DELRAY AVE. BETHESDA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Doreen L. Redfearn 26, 12:15 pm 2000 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Forest Glen Skilled Nursing Center

5. Social Security Number 6. Sex 7. Age (In yrs. Test birthdey) If Under 1 Year Silver If Under 24 Hrs. Spring

B. Dete of Birt Montgomery Birthplace (State or Foreign Country) Dete of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 XF Director Apr 17,1920 England 577-48-9659 Usuel Residence of Decedent Manylend 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes No Directo Silver Spring Maryland Montgomery 10g. Citizen of What Country? Funeral 10000 Brunswick Ave. #408 20910 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No II Yes, Give Yeer or Detes: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Marital Status Biack, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 🎖 ☐ No Specify: Specify: White þ 3 Widowed 4 Doivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Publishing Elementery/Secondery (0-12) Cottege (1-4or 5+) Publisher House' permit. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any injury or other traumatic event, 18 Mother's Neme (First Middle Maiden Surname) 17. Fether's Name (First, Middle, Last) Be Frederick Charles Grant Anne Dillon 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Margaret R. Wolfe/Daughter 10210 Brunswick Ave Silver Spring, MD20902

20a. Method of Disposition | Dete | 20c. Location - City or Town, Stete Baltimore. 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from State 1/19 4 Donetion 5 Other (Specify) Metropolitan Crematory2001 Alexandria, VA Francis J. Collins Funeral Home, Inc. 500 University Blvd W Silver SpringMD enter the mode of dying, such as cardiac or respiratory errest, Approximate 23a, Pert1. Enter the disease, or complications that caused the deeth. Do not en shock, or heart fellers. List only one ceuse on each line. Intervet Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical .Arteriosclerotic Heart Disease Sudden Examiner Due to (or as e consequence of): Examiner certificata be executed signed by the attending physician and d be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): The law requires that the death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Arteriosclerotic Cardiovascular Disease by pege 2 should b 24a. Wes an autopsy performed? 24b. Were eutopsy findings available prior to Completed completion of cause of deeth? certificata has 1 Yes 2 No of Vital Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4\( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 2 1 Yes ≱□XNo this funaral 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Aftert Watural Division Attending ours after deah 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by 4 Homicide \*\*Contifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier December 28, 2000 D 06674 12 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 2309 Shorefield Road, Wheaton, MD Myron L.Lenkin MD

DHMH 16 Rev 6/95

State

Registrar

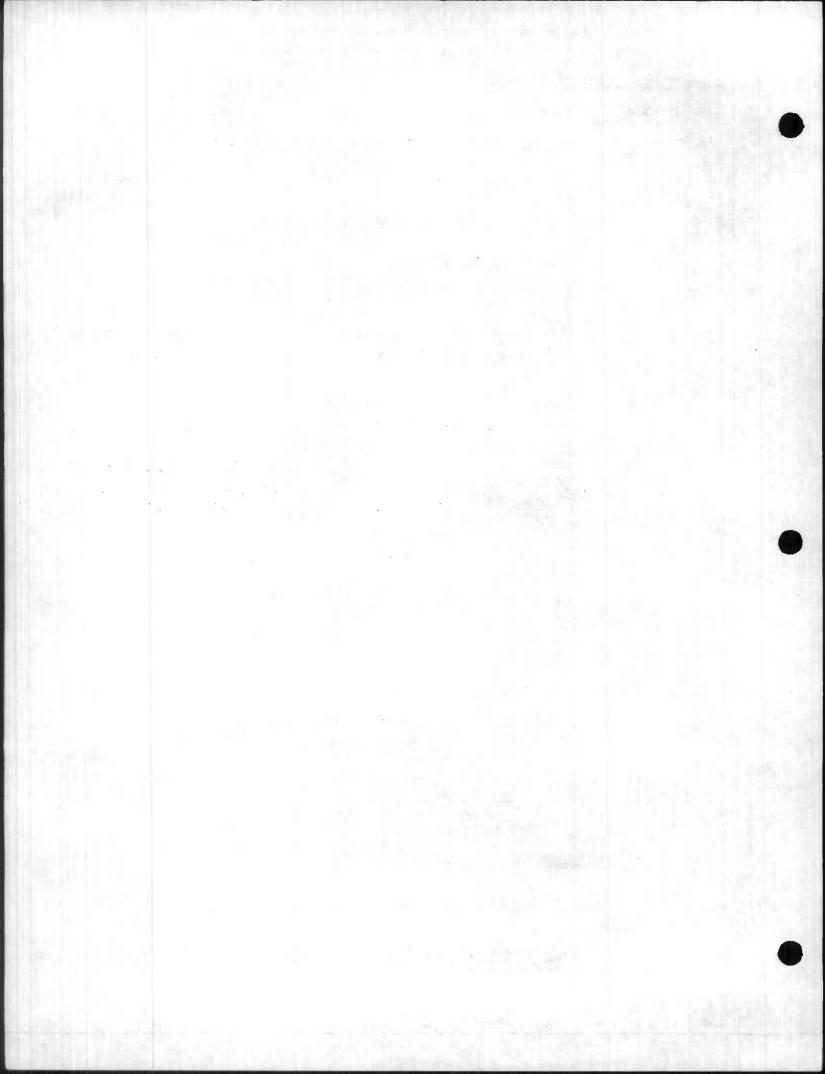
31. Dete filed (Month, Dey, Year)

DEC 2 9 2000

32. Registrer's Signeture

Sparks

ORIGINAL



State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ANTHONY E. RANDOLPH 2000 Dec 9:45 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Elder Care - Genesis Annapolis ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1♥M 2□ F 552-92-2035 Director Dec 10,1953 Kentucky Usual Residence of Decedent 10a. Sfete 10b. County 10c. City, Town or Location 10d. Inside City Limits I Heath and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Wedical Examines must be notified at tyE Yes 2 □ No Director Anne Arundel Jessup 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7810 Clark Rd # c-23 20794 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Merital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Tractor Operator U.S.D.A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) d 2 should be fi th and Mental H 7 is marked of Johnny J. Randolph Nannie Tyler 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2: Department of Health at Important: If Item 27 is any Injury or other trau pncs. Desiree D. Randolph (Dau.) 8517 Locust Grove Dr., Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 XBuriel 2 ☐ Cremetion 3 ☐ Removal from State Md. Nat'l Mem. Park 12/30/00 Laurel, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licentum 22. Name end Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediete Ceuse (Finel disease or condition resulting in death) /Medical Kenal Examiner Que to (or as a consequence of): Examiner hysician and the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of) attending physician Physician/Medical Due to (or as a consequence of): use es the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 VInknown P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 No I or Attanding Physician: after deeth. Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homlcide To the Hospital within 24 hours a To the Funeral D completely filled in 1St. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end Im 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Annopoles load #106, ochenton MDa1113 Da Sulku , el 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar DEC 29









State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Deeth 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day **Physician** William Thomas Sherman Dec 24 2000 0936 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminster Carrol1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sax Birthplace (Stete or Foreign Country) **Funeral** Days MM 2□F Director 219-20-0788 90 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1808 Old Taneytown Road 21158 USA 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, atc.) Race - American Indian, Black, White, etc. or Herna 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Dates: 1 Naver Married 2 Married White 1 Yes 2 No Specify: py 3 ₩ Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) I Hygiene. Carroll County Elementary/Secondary (0-12) College (1-4or 5+) Roads Department Supervisor 8 18. Mother's Name (First, Middle, Meiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic even DDCB. 17. Father's Name (First, Middle, Last) Charles Edward Sherman Daisey Coleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles Sherman/son 178 W. Main Street Westminster, MD 21157 20b. Place of Disposition (Name of camefery, cremetory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Keysville Cemetery 12/28/2000 Keymar, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funaral Service Licansae Pritts Funeral Home and Chapel K 412 Washington Rd Westminster, MD21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** 20 Immediate Cause (Final disaasa or condition resulting in daath) /Medical **Examiner** Due to (or as a consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequenca of): the Dua to (or as a consequence of): usa as for Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by tha 1 Yes 2 Wo 3 □ Probably 4 □ Unknown to inlet or þ after death.

Director: After this certificata has been sign of the funaral director, page 2 should? 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? Be Completed 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 28. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 INatural 5 Panding 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicida 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 29a Certifier 1 Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D18 200 Daws 12/24/00 Wadsell V West minter D 2115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHITRACHEDY NACIANNA ND. 700 A poole del

State Registrar 31. Date filed (Month, Day, Year)

**DEC 27** 

**DHMH 16 Rev 6/95** 

filed within 72 hours after death

Maryland 21215-0020

Baltimore,

The law requires that the death certificate be executed

Box 68760,

P.O.

Records,

of Vital

Division

or Attending Physicien:

To the Hospital

32. Registrar's Signature

050 C S 7 2000 January

Truck Driver

20b. Place of Disposition (Name of cametery, cremetory or other place)

Sunset Memorial Park

r than "natural", or learns 23a or 28a-f show the Madical Examiner must be notified at Saltimore, Maryland 21215-0036 Ē should be and Mental le marked Pages 1 and 2 s ment of Health an ant: If hem 27 is y

**Physician** 

/Medical

Examiner

Directo

Funeral

by

Completed

**Funeral** 

Director

Harold

10a State

MD

Physician/Medical Examiner signed by the attending physician and d be deteched for use as the burial-transit certificate be executed by Completed page 2 should peen The law brai Director: After this certificate has filled in by the funeral director, page 2 Physician: Be 2

P.O. Box 68760,

236-01-8911

HAROLD SENCINDIVER

Division of Vital Records, Certification: or Attending after within 24 hours at To the Funeral D completely filled Hospital edicai 6

death

mal

State Registrar

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) Poonai, Vik, M.D. 31. Date filed (Month, Dey, Year) DEC 2 8 2000

32. Registrar's Signature

28a. Data of Injury (Month, Day Year)

pack

ORIGINAL

Physician /Medical Examiner

Immediate Cause (Finel disaasa or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disaasa or injury thet initieted events resulting in death) Last

25. Was case referred to medical examiner?

5 Panding investigation

6 ☐ Could not be

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicida

29b. Signefure end fitte of the

17. Father's Name (First, Middle, Last)

Judy A. Emmart Daught Sisposition

19a. Informant's Name/Relationship (Type, Print)

4 □ Donefion 5 □ Other (Specify)

Grover Cleveland Sencindiver

Burial 2 Cremation 3 Removal from State

Due to (or as a consequence of): Congestive Heart Failure Due to (or as a consequenca of):

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of injury

28e. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify)

Cardiomyopathy

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or es e consequence of)

23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy performed?

1 Yes 2 No 3 Probably 4 Unknown

1 ☐ Yes 2 No

Trucking

20c. Location - City or Town, State

Cumberland, MD

18. Mother's Name (First, Middle, Maiden Sumeme)

12/30

2000

Grubb

Laura V

Cumberland, MD 21502

19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 11018 Raven Dr. NE; Cumberland MD 21502

Scarperdis of Füheral Home, P.A.

24b. Wara autopsy findings available prior to completion of cause of death?

Approximate Interval Betw Onsat end Death

3 years

1 week

28d. Dascribe how injury occurred

5 ☐ Residenca 6 ☐ Other (Specify)

26. Place of Death (Check only ona)

1 ☐ Yes 2 ☐ No

1 Conting Physician: To the best of my knowledge, daath occurred at the fima, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to the ceuse(s) end menner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Other: 4 Nursing Home

1 ☐ Yas 2 ☐ No

D36766

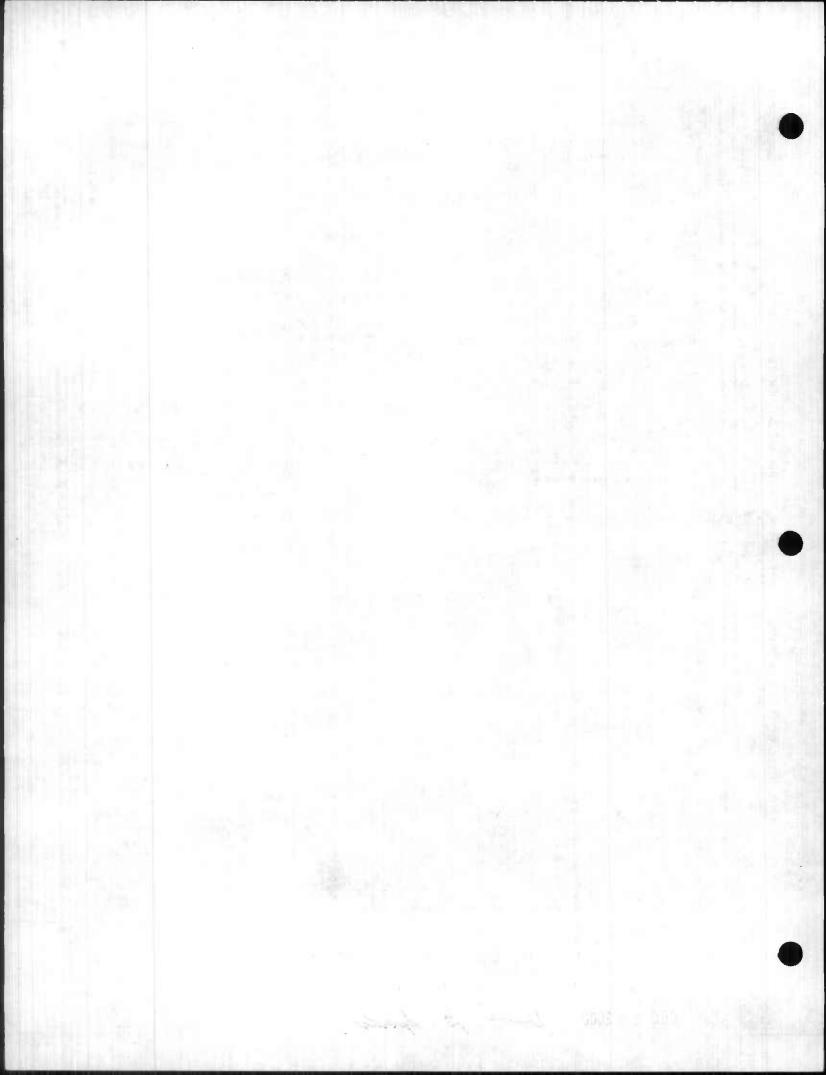
December

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28c. Injury at Work?

28,2000

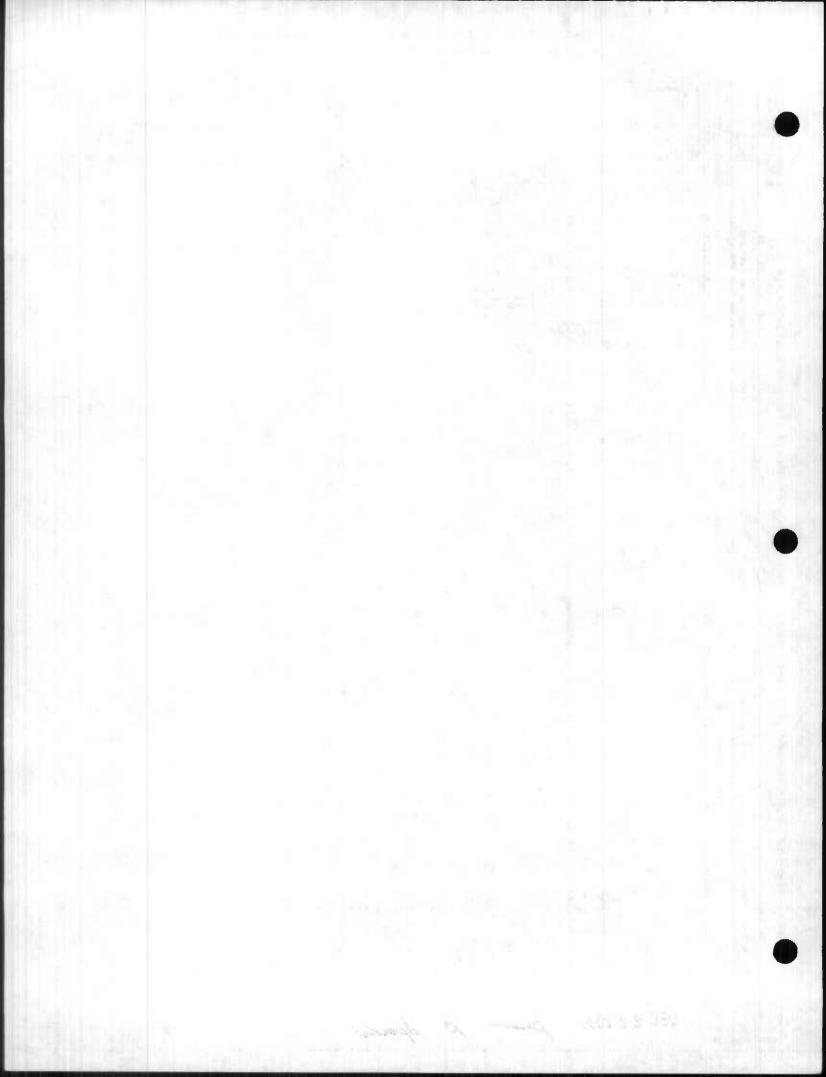
920 National Highway LaVale, Maryland 21502



State of Maryland / Department of Health and Mental Hygiene

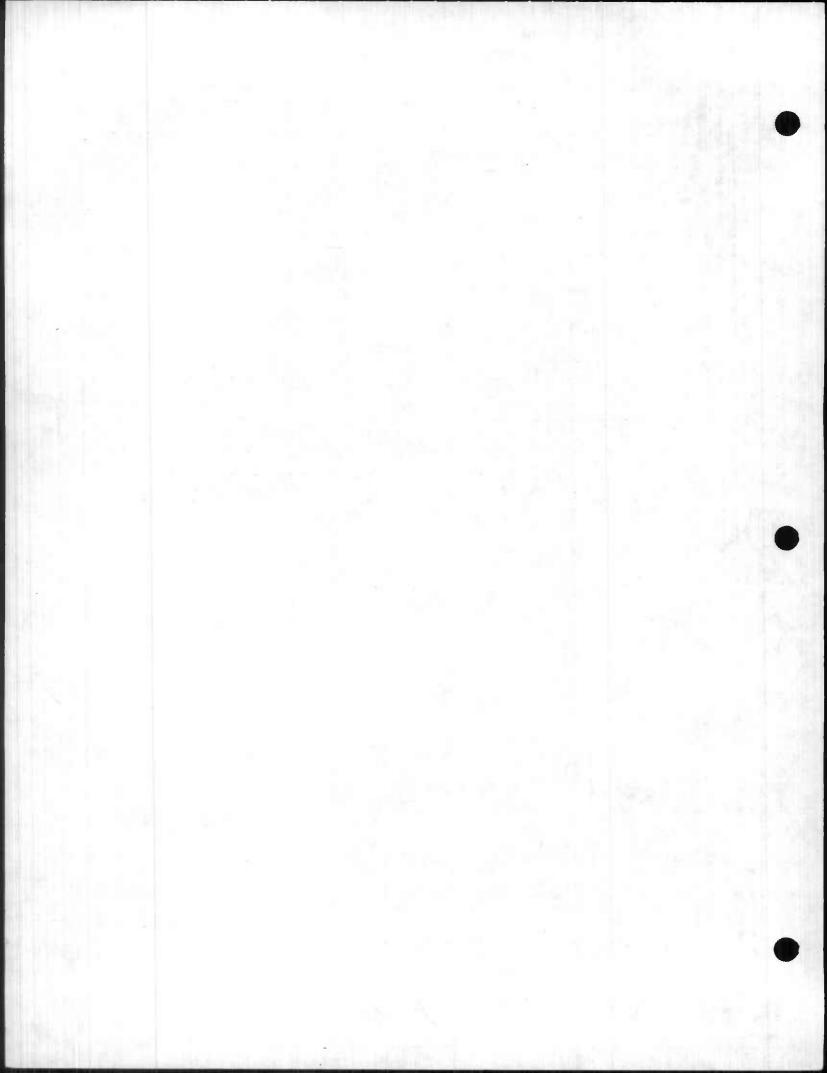
			Ce	ertificate of	Death	Reg	J. No.	2000
	Physician	Decedent's Name (First, Middle, Last)     Rachel Eliz	abeth Sumr	merfield		2. Data of Death Dec 27	, Day 2000 Year	3. Tima of Death 02:45am
	/Medical Examiner	4s Facility Name (If not institution, give street and Cumberland Nursing			4b. City, Town, or Lo Cumberla		4c. County of Death	egany
	Funeral Director	5. Social Security Number 6. Sax 1 M 2 3	7. Age (In yrs. last birthday 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day Mar 21	(ear) 1912 9. Birth	nplace (State or Foreign
	8 .	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	anation.				40d Incide Ob Limbs
	ar death with the Maryla terms 23s or 28s-f shor net must be notified at unerral Director	MD Allegany		mberland				10d. Inside City Limits 1 □ Yes 2 □ No
	23s or 2 untbe na	10e. Street and Number 1108 Kentucky Aver	iue	10f. Zip Code	21502	109	g. Citizen of What Cor USA	untry?
20	s attar des samines in y Fune	1 Never Married 2 Married 1 Yes	Decedent Ever in U,S. 13. 1 Forces? es 2 1 No , Give or Dates:	. Was Decedent of H If Yes, specify Cuba 1 Yes 2 Ho	tispanic Origin? (Span, Mexican, Puarto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specifywhi	, etc.
21215-0020	hursi al E	15. Decedent's Education		edent's Usual Occup	setlon	16	6b. Kind of Business/I	
5	n 72 r - rast ledic olete	(Spacify only highast grada complat	ed) (Give	e kind of work done  DO NOT use retired	duning most of work	ing	oo. Kind of Oddinessi	ndostry
212	ygiene. Ner then nt. the Me	Elemantary/Secondary (0-12) Colleg	ID (1-407.5±)	maker			wn Home	
and	id be filled ental Hyg ked other ic event, I	17. Father's Nama (First, Middle, Last) Elijah H. Davis			18. Mother's Name Ella M	(First, Middla, Ma (White		
Mary	12 should he and Mark he mark	19a. Informant's Name/Relationship (Type, Print) Barbara J. Terrill	19b. Mail 145	ling Addrass (Street	and Number or Run	al Route Number, Cresap	City or Town, Stata, Z	ip Code) 21502
more,	or other	daughter 20a. Method of Disposition 1 Burlal 2 Cremation 3 Removal fr	20b. Place of Disp cemetery, cre	position (Name of ematory or other place	ce)	Date 12/29	Oc. Location - City or	Town, State
Ē	Page 1	4 □ Donation 5 □ Other (Specify)		Memorial	Park		umberlan	
Balt	Depart Import any inj ance	21. Signature of Funeral Service Licensee	N. A. A. A. A. A. A. A. A. A. A. A. A. A.	scarperi Cumberla			P.A. 21502	
		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	at caused the death. Do not ar	nlar tha mode of dyir	ng, such as cardiac	or raspiratory arres	st,	Approximata Interval Between
	Physician	SHOOK, OF HEALT FAILURE. LIST OFFING PAUSE	on each mie.					Onset and Death
	/Medical Examiner	Immediata Cause (Final disease or condition rasulting In daath)	Reual  Due to (or as a conse	failure				2 week.  3 worths.
	D = D		Delich	chin				2 week.
	executed in end iel-transit	Sequentially list conditions,	Due to (or as a conse		0			
68760,	hysicia the bur	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last	Cerabrio Dua to (or as a conse	vasula equance of):	n disea	re		· 3 worts.
Box 6	M Bee	d						
0	0 0 0	Part II. Other significant conditions contributing t	o death but not resulting in the	underlying ceuse giv	ven in Part I.	23b. Did tob	acco uss contribute	to the cause of death?
0	es that the de igned by the be deteched by Physic					1 🗆 Yes	2 No 3 ₽	obably 4 Unknown
of Vital Records,	seen s hould					24a. Was an perform	ed?	Were autopsy findings available prior to complation of cause of death?
Re	hes pe 2					1 ☐ Yas		I □ Yes 2 □ No
ita	certificate rector, par	25. Was cese referred to medical examiner?			26. Place of Deat	h (Check only one	)	
> >	Z o D	1 Yas 20 No Hospital:	☐ Inpatient 2☐ ER/Outpatie	ent 3 DOA Oth	ner: 4 Nursing Ho	me 5 Residen	nce 6 Other (Spec	cify)
	ding Ph. th. After th funerel	27. Manner of Death  1 Natural 5 Pending (*)  Accident investigation	ata of Injury Month, Day Year) 28b. Time Injury	Wo	ry at rk? Yes 2 □ No	28d. Describe how	v injury occurred	
Division	lal or Attending P rs after deeth. al Director: After t led in by the funers Certification:	3 Suicide 6 Could not be date mined	lace of Injury - At home, farm, s uilding, atc. (Specify)	treet, factory, office		28f. Location (Stre City or Town,	eat and Number or Ru State)	iral Route Number,
	Hospi 4 hou Funer tely fill	(Check only 2 Medical Examiner: On the	the best of my knowledga, dea a basis of axamination and/or in nanner stated.	ath occurred at the time	ma, date and place, opinion, death occur	and due to the cau red at the time, dat	usa(s) and manner as te and place, and dua	stated. to the causa(s)
	Within 2 To the complete	29b. Signature and title of certifier	un/ Mo	29c. Licens			d. Date signad (Mont)	
•	5	30. Name and address of person who completed	- (-1	Print)	7 ( ) .	. 60.00	ind of	27,2000
	mll State		302 SCI 2. Registrar's Signature	ney'st	· cecu	weith	no, ve	
	Registrar	DEC 2 8 2000 Same	da & So	and I				
DH	MH 16 Ray 6/95		1					

**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene 0 42884

			C	ertificat	e or	Death		Reg	J. No.		
Physician /Medical	1. Decedent's Neme (First, Middle CAROL	BELL	STORM				DEC	e of Death nth EMBER			3. Time of Deeth 2:05 PM
Examiner	4e Facility Neme (If not institution WILSON HEALT					GAITHE	ERSBUR	G	4c. County of MONT(		RY
Funeral Director	5. Sociel Security Number 220 46 4821	6. Sex 7. Age 1	96 Yrs.	y) If Under Months	Deys	If Under 24 h	Ain. 6. Dat	of Birth VE 30	,1°904	9. Birth	RYLAND
2 1.	Usuel Residence of Decedent  10a. Stete 10b. County		10c. City, Town or	Location						1	Od. Inside City Limit
ar death with the Marya there 23e or 23e-f sho ner must be notified at uneral Director		GOMERY	GA	THERS				140	0.00		yes 2□N
23a or unit be or rai Dir	10e. Street and Number 301 RUSSELL	AVENUE			0877				g. Citizen of W		•
at, or harra 23 Examiner must by Funeral	11. Meritel Stetus  1 Never Married 2 Merri  3 Wildowed 4 Divorced	12. Wes Decedent I Armed Forces? 1  Yes 2  1 If Yes, Give Yeer or Detes:	Ever in U,S. 13	3. Was Dece If Yes, spe	1	lispanic Origin? en, Mexican, Pu Specify:	? (Specify Ye uerto Ricen, (	s or No- etc.)		, White,	ean Indien, etc.
ygiene. ser than 'natura t, the Medical Completed	15. Decedent (Specify only highes Elementary/Secondery (0-12)	cs Education t grade completed)  College (1-4or 5	(Gi	cedent's Usu ve kind of wo DO NOT u	rk done se retire	during most of	working	16	Sb. Kind of Bus	siness/în	dustry
Mental Hyg sriked other affic event. To Be C	17. Father's Neme (First, Middle, GEORGE LAWRE					18. Mother's I		Middle, Ma ZABET	aiden Sumeme H	KEMP	ER
Z7 is ma r trauma	19e. Informant's Neme/Relational F. PHILIP STORM					and Number of					
tment of He tant: If hem jury or other	20e. Method of Disposition  1 Burial 2 Cremetion  4 Donetion 5 Other (Sp	3 □Removel from Stete	20b. Plece of Dis	position (Ne.	me of other plea	ce)	12/29	20	PIKESV	City or To	own, State
Departri Importa any inju	21. Signeture of Funerel Service I	icensee // Ba	rher			ss garber 5038, l				208	82
anding physician and was as the burial-transit use as the burial-transit use as the burial-transit usedical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth)  Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last	b. hyp	Due to (or es e cons	equence of)		) leer	4				lweck, years
ed by the attent detached for u	Pert II. Other significant condition	ns contributing to death bu	ut not resulting in the	underlying	ause giv	ren in Pert i.	23			tributa t	o the causa of dea
us been sign 2 should be pleted by							24	a. Wes en	autopsy	24b. W	ere autopsy finding eileble prior to impletion of cause death?
Sate he page		115 6 1 5 - 1						1 🗆 Yes	2 No	10	☐Yes 2☐No
s certificate director, pa	25. Wes cese referred to medical axaminer?	Hospital:			Oth	26. Place of				. =	
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or Attended bleed birector: in by the ertifical	2 Accident Investig 3 Suicide 6 Could reference 4 Homicide	etion ot be	ury - At home, ferm,	М	10	Yes 2□No		cation (Stre y or Town,		er or Run	el Route Number,
he Hospital in 24 hours he Funeral plataly filled edical Co		Physician: To the best of each menner ste	exemination end/or								
To the compla	29b. Signeture and fittle of certifier	- 1) oli			c. Licens	o l 4	8		d. Date signed	(Month,	26 20
State	30. Neme and eddress of person of the state	isky mp	- 911 (arris Signeture	Susse	1 /	tre,	Szeth	cish	veg,	M	۵.

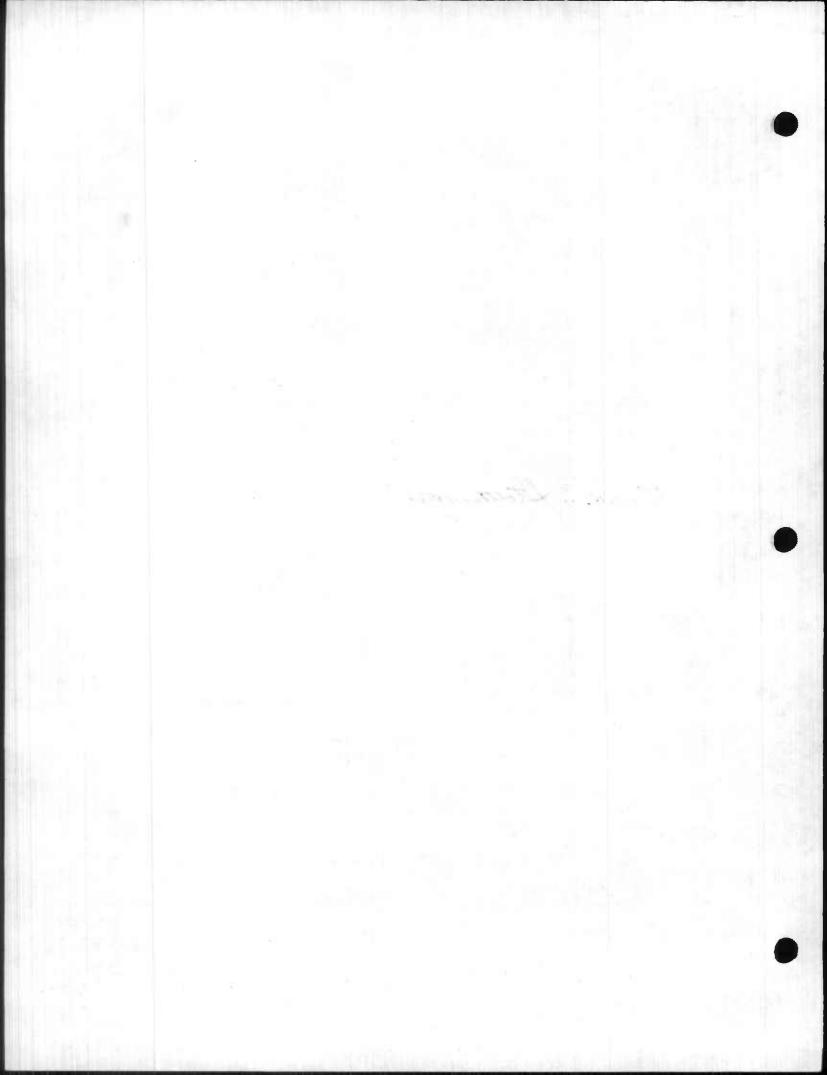


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 19 2000 DEC. 5:00 AM ANNE STERNBERG /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCKVILLE MOI

Jnder 24 Hrs. 8. Date of Birth
(Month, Day, Year) HEBREW HOME OF GREATER WASHINGTON MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1□M 2K)F Days Months Hours 95 JULY 11 Director 130-24-3643 NEW YORK Usual Residence of Decedent with the Maryland 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits rai', or items 23s or 28s-f show Examiner must be notified at Yes 2 □ No Director MONTGOMERY ROCKVILLE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or 6121 MONTROSE RD Funeral U.S.A.

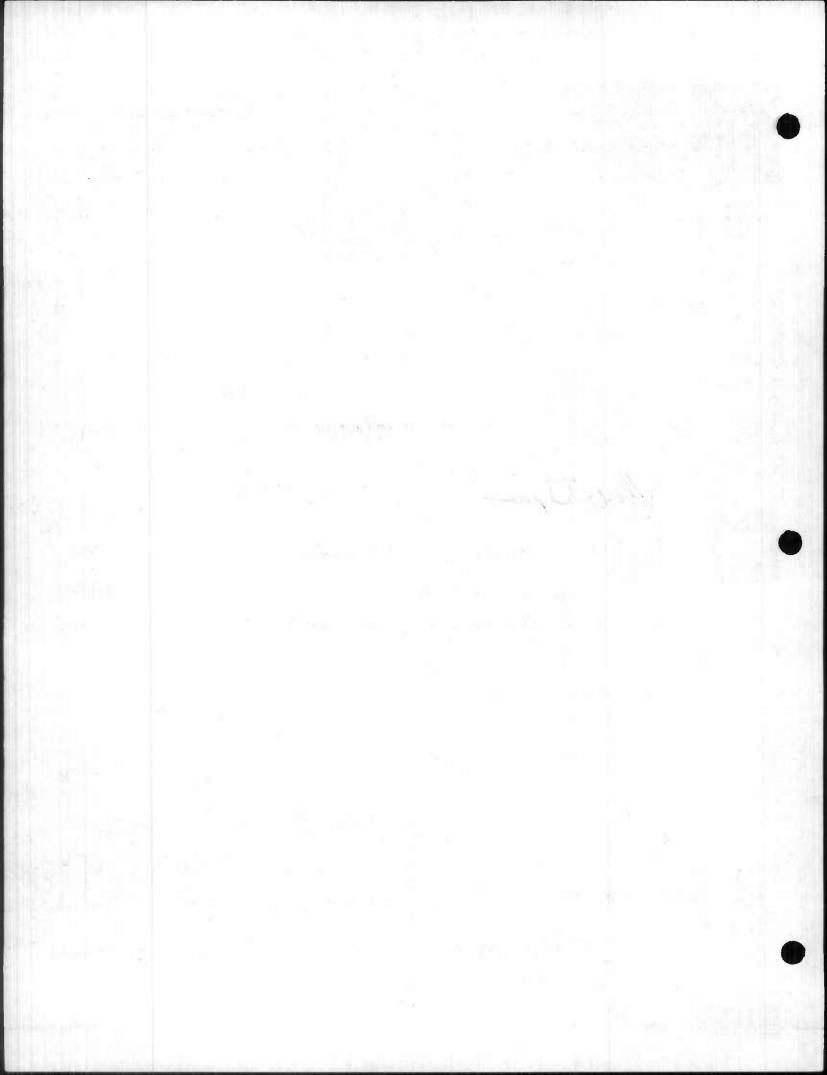
14. Race - American Indian,
Black, White, etc. deeth 20852 12. Was Decedent Ever in U,S.
Armed Forces?
1 □ Yes 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 72 hours efter 1 Never Married 2 Married Saitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Health page. Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 FUR INDUSTRY SECRETARY 17. Fether's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JACOB ZIMMERMAN MARY SHARFSTEIN 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SIMA WEITZMAN/DAUGHTER 255 W 88th STREET NEW YORK, NY 10024 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12/20 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH DAVID CEMETERY 2000 ELMONT, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Pert1. Enter the disease, or complications that caused the seith. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) CEREBRAL THROMBOSIS /Medical 2 WEEKS Examiner Examiner ATHEROSCLEROSIS The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): end Box 68760. Physician/Medical Due to (or es e consequence of): signed by the at P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? ESSENTIAL HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Division of Vitai Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed paga 2 2000 1 Yes 1 Yes 2 No certificate or Attending Physician: 25. Wes cese referred to medicel examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medicai Certification: To this 27. Mennes of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28h Time of 28c. Injury at Work? After 1 Matural 5 Pending investigation 24 hours after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 To the \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contilled 0 30. Name and address of person who completed ceuse of deet/ (Item 23e) (Type, Print) OCKULLE MO 20852 MiD MONTROSE 10/21 31. Date filed (Month, Day, Year) DEC 2 6 32. Registrar's Signature State 2000 Registrar



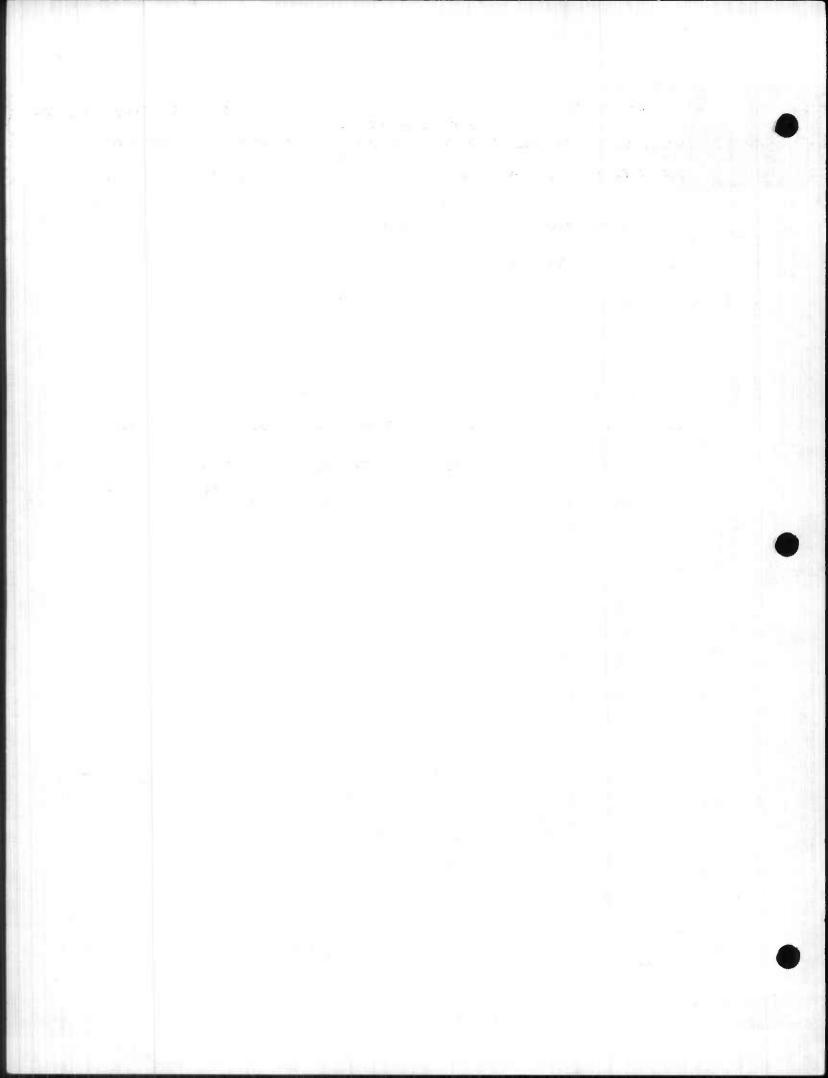
State of Maryland / Department of Health and Mental Hygiene 00 42886

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	sicla: edica	n	1. Decedent's Name (First, Middle, I Ruth M. Smith	Last)							2. Dete of D Month Decemb	Dey	Yeer 2000		me of Death	
	mine		4e. Fecility Neme (If not institution, g	rive street end n	umber)				4b. City, 1	Town, or L	ocation of Dee		ounty of Dee		JV an	
Fune Direct			089-26-7711	rsing H Sex 1□M 2√xF		vrs. lest birthdey, Yrs.	If Under	er 1 Yea			(Month, D	irth		mery thplece (St buntry) York	tete or Foreign	
pu »			Usuel Residence of Decedent  10e. State 10b. County		100	City, Town or Lo	contina									
the Maryla 28a-f shor			New York Nass	au	100.		ksvil				3	40 000		10d. Inside City Lim 1 ☐ Yes 2 ☑ I		
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Z13-UUZ Ihin 72 hours a. In "natural",		2	15. Decedent's	Education	,	16e. Dece	dent's Us	uel Occ	upation	at of word	de e	16b. Kind	of Business			
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		0	William Marshal	1												
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permit. Pag Department Important: I any injury o	DUCE		21. Signature of Ameral Service Lio		_	T.	xana-	. 1	ress of Fedi	lina	Funera	1 Home	, Inc	·	20001	
Physicia /Medic	_		23a. Parth Enter the disease, or co shock, or heart feilure. List onl	mplications thet by one ceuse on		~				s cardiac	or respiretory	errest,	SPLIN	Approx Interve Onset	ximete el Between end Deeth	
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nding use as	n/Me	an vince	issuiting in death, cost	■ d												
daath he atta	Physicia	5	Pert II. Other significant conditions	contributing to d	leath but not	resulting in the u	ınderlying	cause	given In Per	t I.	23b. Did	i tobacco us	e contribute	to the ca	use of death?	
requires that the daath	hy Dhy										1□	Yes 21X	No 3□P	robably	4 Unknown	
ha iaw requires the has been signed by the second be the second by the s	1										24e. Wes	s en eutopsy ormed?		Were auto eveileble p completion of death?		
Tha iaw ate has b	E	5									1 कि	Yes 2□N	No	1 🗆 Yes	20 No	
defan: The certificate rector, peg	a a		25. Wes cese referred to medical						26. Ple	ce of Deel	th (Check only					
Physician: This certificate director, pe	2		examiner?	Hospital:	Inpatient 2	ER/Outpetie	nt 3 🗆 🗅	OA C	Whore		ome 5□Res		Other (Spe	icify)		
tanding Phyleath. lor: After thi			27. Manner of Deeth  1 Naturel 5 Pending 2 Accident Investigeti	28e. Dete (Mor		28b. Time o		28c. In			28d. Describe					
Hospital or Attanding 124 hours after death. Funeral Director: After stely filled in by the fune	Certification.		2 Accident Investigeti 3 Suicide 6 Could not 4 Homicide determine	be 28e. Plec	e of Injury - A ling, etc. (Spe	at home, farm, streetify)					28f. Location City or To	(Street end Nown, Stete)	lumber or R	urel Route	Number,	
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	policai		29e. Certifier (Check only one)	miner: On the b	e best of my k basis of exem oner stated.	knowledge, deet inetion end/or In	h occurred vestigatio	d et the n, in my	time, dete e opinion, de	end plece, eeth occur	end due to the red et the time	ceuse(s) en , dete end pla	d menner es ace, end due	steted.	use(s)	
To the i	Z		29b. Signeture end title of certifier	/			29	c. Lice	nse number			29d. Dete s	igned (Mont	h, Dey, Ye	nar)	
18			1844	9WE. 1	WD			73	3700	)		Decei	mber.	21,20	000	
		2 2	1EDE. HOWE	154 N	se of death (I	TANST.	Print)	LIF	HMSP.	TSPO			795			
-	State	3	31. Dete filed (Month, Dey, Year)	2000 32.1	legistrer's Sk	gneture A	L	no A	1		•					



State of Maryland / Department of Health and Mental Hygiene

					Certific	ate of L	Death		Reg. No.	420	001
Physicia	an	1. Decedant's Nema (First, Middle, L	ast)					2. Dete of De Month	eth Day	Yeer	3. Time of Death
/Medic		Edna Smith						12	24 2	2000	10:20PM
Examin		4a. Facility Neme (If not institution, gr									
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uneral Director		5. Sociel Security Number 6. 258 24 8807 Usual Residence of Decedent	Sax 7. A 1 M 2 X F	79		hs Deys	Hours Min.			9. Birthpled Country Georg	ca (Stata or Fore
MOL N		10e. Stete 10b. County		10c. City	y, Town or Location					10d	I. Inside City Limi
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or 28	Director	10e. Street and Number				Zip Code			10g. Citizan of	Whet Country	1?
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items recm	Funeral	11. Meritel Stetus	12. Wes Decedent Armed Forcas	Evar in U,	S. 13. Wes De	ecedent of Hi	ispanic Origin? (S n, Mexican, Puert	pecify Yas or No		ca - Amarican	
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"natural", edical Ex	Be Completed	15. Decedent's E (Specify only highest gi	ducation		16e. Decedent's U (Give kind of life. DO NO	Isuel Occupa	ation	rkina	16b. Kind ot B	lusiness/Indus	stry
then "	nple	Elementary/Secondery (0-12)	College (1-4or	5+)	life. DO NO	Tuse retired,	)	King			
ther th	S	12			Collecti	on Age				LStore	2
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marked o	2	Oscar Bridges Sm	ith				Ella Mo	ore			
		19e. Informant's Name/Reletionship			19b. Meiling Addi					, State, Zip Co	ode)
item 27 other tr		Jane M. Bloss/ Po	ower of At				dge Road			20906	
		20e. Mathod of Disposition  1   ↑ Burlei 2 □ Cramation 3 [	Removal from Stata		leca of Disposition ( ematery, cremetory	Name of or other plec	a)	Dete	20c. Location	- City or Towr	n, State
ury		4 □ Donation 5 □ Othar (Spec			lar Hill (	Cemete	ry 1	2/29/00	Suitlan	nd, MD	
Important: H any injury or		21. Signatura of Funarel Servica Lice	nsee		22. Name	and Addres					
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		234. Pert1. Enter the disease, or con shock, or haart failure. List only	plications thet causa	d the deeth	n. Do not enter the r	node of dying	g, such as cardia	or respiretory e	rrest,		pproximete itervel Batween
/sician		U Shock, of heart failure. List only	one cause on eech i	me.						O	nset end Deeth
ledical		Immediate Cause (Final disease or condition	CON	680	STIVE	+18 A	RT I.	PINR	S	1	
aminer		resulting in death)	e		r es e consequenca			ILUN			
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the eth	Sic	Pert II. Other significant conditions	contributing to death t	out not rasu	liting in the underlying	ng cause give	en in Pert I.	23b. Did	tobacco use co	ontribute to th	he cause of deat
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igned t	S Y	Kehal M	Suffici	ED	C9.			1			
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2 =		27. Manner of Deeth	28a. Dete of Inju		28b. Time of	28c. Injury Work			how injury occu		
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	E C	3 ☐ Suicida 6 ☐ Could not I determined	28e. Place ot In	jury - At ho	ome, farm, street, fac	tory, office			Street end Num	ber or Rural F	Route Number,
octor: A	ert	4   Homicice	building, et	tc. (Specify	"			City or To	wn, Stete/		
Director d in by th	4.5	,	hysician: To the best	of my know	wledge, deeth occurr	red et the tim	ne, dete end pleca	, end due to the	cause(s) end m	enner es state	ed.
neral Director filled in by th		29a. Certifier Certifying P	malman. On the beaters	t examinet	ion end/or Invastigat	tlon, in my op	oinion, deeth occu	rred et the time,	dete and plece,	end due to th	ne cause(s)
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ompletely filled in by th	Medical C	(Check only 2   Medical Exa	end menner si	ateu.		29c. License	number	T	29d. Dete signe	ed (Month, Da	ıy, Year)
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To the Funer completely fil		one) 2 Medical Exa	end menner st	death (Item	23e) (Type, Print)	1100		6	12/	256	0,



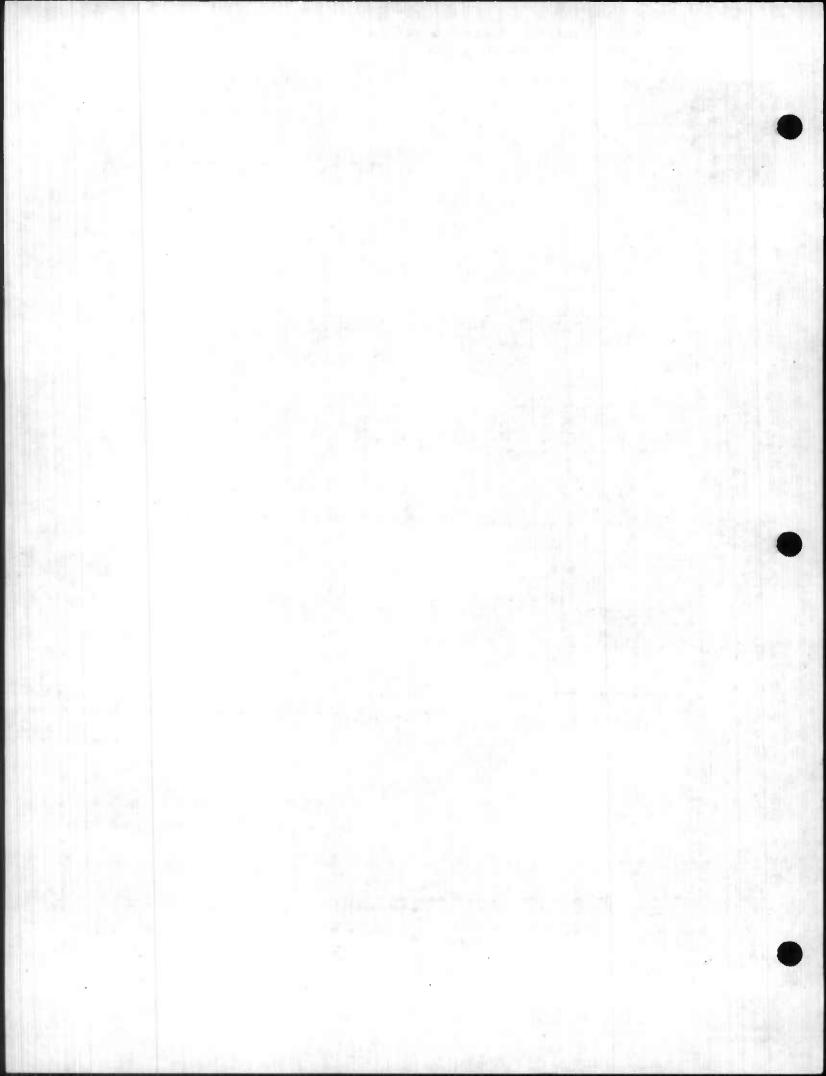
Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Month Day Veer **Physician** 9:11 pm Alberta Carolina December Simon 2, 2000 /Medical 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brighton Gardens Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Deys Hours Min. JAN. 25, 1914 5. Social Security Number 7. Age (fn yrs. lest birthdey) Birthpleca (Stete or Foreign Country) **Funeral** Months 1□M 201F Pennsylvania 86 190-24-3893 Director Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a State 10b County Maryland Montgomery Bethesda 1 N Yes 2 No Director Herne 23s or 28s-ner must be notifi 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 5550 Tuckerman Lane #352 20852 Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Yaar or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, Bleck, White, etc. 11 Marital Status the Medical Examiner 1 □ Naver Merried 2 □ Merried Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) 86 2 should be 1 and Mental h Charles Osterholm marked Charlotte Bensen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Pages 1 and 2 ament of Health an ant. If Item 27 is r lury or other traus 11308 Crossing Glen Ct., Potomac, MD 20854 Carol Margolis / Daughter Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 1 DBurial 2 Cremetion 3 Removal from State 12/28/00 Pittsburgh, PA Beth Shalom Cemetery 5 Other (Specify) <sup>22</sup>. Name and Address of Fecility.
Danzansky Goldberg Memorial Chapel, Inc 1170 Rockville Pike, Rockville, MD 20852 23a: Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Fine) disease or condition resulting in deeth) heimus Examiner Due to (or as a consequence ot) Examiner certificate be executed physician and s the bunal-trans Sequentially list conditions, if eny, leeding to immadiate ceuse. Enter Underlying Cause (Disease or injury that Initieted events resulting in death) Lest Due to (or as a consequence ot): P.O. Box 68760. Physician/Medical Due to (or as a consequence ot): 88 158 ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown heart racie Division of Vital Records. by 24b. Were autopsy findings available prior to complation of causa of deeth? 24a. Wes an autopsy performed? Completed page 2 s has 1 Yes 2 NO 1 ☐ Yas 2 ☐ No certificate 25. Was case reterred to medicel axaminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 No 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred After or Attending 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 28t. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the Hosp within 24 hor To the Fune completely fi edicai (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) December 26, 2000 mi 10 30. Name and address of person who completed causa of daath (Item 23a) (Type, Print) GAITHERSOUNG. MELNICH JOHOO

State

31. Date filed (Month, Day, Year) DEC 2 7 2000 Registra

911 RUSSELL 32. Registrer's Signature



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7:50 AM DECEMBER 25, 2000 ANITA GAYLE SELMAN 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give streat and number) MONTGOMERY POTOMAC 12115 LITTLE CREEK DRIVE If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Pay, Year) 05/29/1952 Birthpiace (State or Foreign TEXAS 5. Social Sacurity Number 6 Say 7. Aga (In yrs. last birthday) Months Days Hours Min 1 □ M 2 🔀 F Yrs. 454-98-5959 48 Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 Yes 2 □ No MONTGOMERY POTOMAC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20854 USA 12115 LITTLE CREEK DRIVE 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 🕱 No 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Biack, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education 16e. Decedent's Usuai Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Spacify only highest grade completed) Etementery/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) JEANETTE DUNCAN JACK COOPER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20854 12115 LITTLE CREEK DRIVE, POTOMAC, MARYLAND THOMAS SELMAN/HUSBAND 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State DEC 26, 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 Donation JUDEAN MEMORIAL GARDENS 5 ☐ Other (Specify) 2000 OLNEY, MARYLAND 21. Signature of Fune 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 20852 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND se or competations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one ceuse on each line. Approximate Interval Between Onsat and Death Immediate Cause (Final diseasa or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated avents resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part it. Other algrificant conditions contributing to deeth but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably Onknown 24b. Were autopsy findings aveilebie prior to completion of causa of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was cese referred to medicai 26. Place of Death (Check only one) Other: 4□ Nursing Home 5 Residence 6 □ Other (Specify) 1 Yas 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural

Examiner buriel-tran The law requires that the death certificate be exer P.O. Box 68760. Physician/Medical esn ate hes been signed by the ette page 2 should be deteched for Records, certificate Division of Vital or Attending Physician: director. this After

þ Completed Be Certification: To s efter death. in by Hospital • Funeral

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

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permit. Page Department Important: If any Injury or

**Physician** /Medical

**Examiner** 

Director

Funeral

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21215-0020

Baltimore, Maryland

within 2 To the To the

29b. Signature 11 title of certifier

6 Could not be determined

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, dete end piece, end due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and eddress of person who completed cause of death (item 23a) (Type, Print) 1928 KARIN

18111

22832

31. Date filed (Month, Day, Yaar) State Registrar

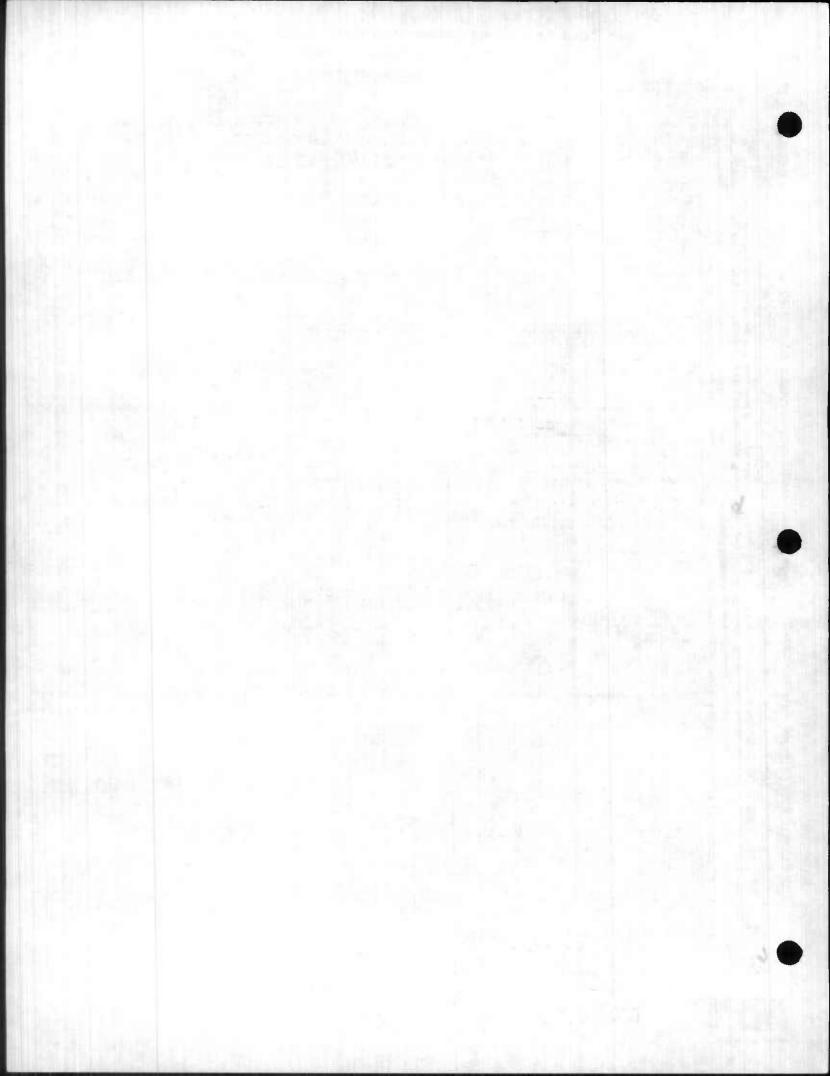
Medical

**DEC 29** 2000 32. Ragistrar's Signature



State of Maryland / Department of Health and Mental Hygiene

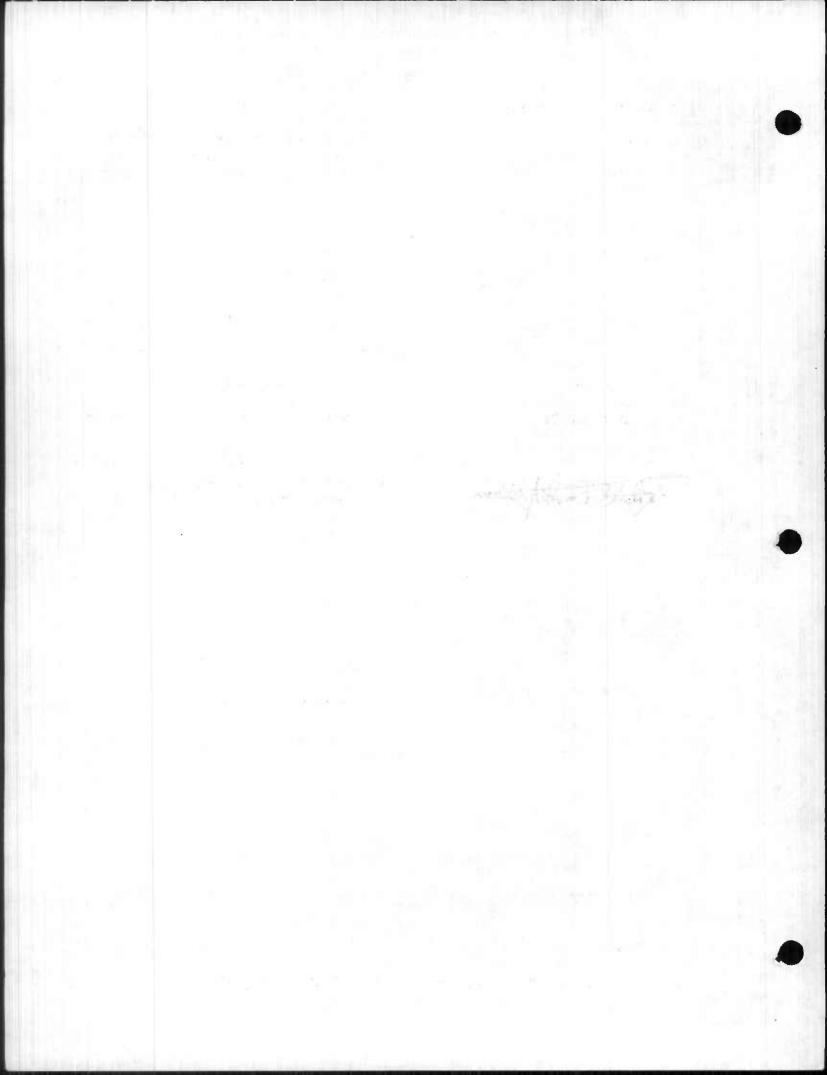
				Certifica	te of	Death		Reg. No.	428	U
Physician	1. Decedent'a Name (First, Middle, Las	st)	(-(1)-0)			1000	2. Dete of De Month	Day	Yeer	of Death
/Medical	CARROLL	0. 000	TT				DEC.			55 PM
Examiner	4a Facility Name (If not institution, given SHADY GROVI		ST HOS	SDTTAT.		4b. City, Town, or ROCKV			of Death TGOMERY	
Constant	5. Social Security Number 6. S		In yrs. last bir	thday) If Und	er 1 Year	If Under 24 Hrs	8. Date of Bir	rth	Birthpiace (State Country)	or Foreign
Funeral Director	220-28-6162 Usual Residence of Decedent	C C.		Yrs. Months	Days	Hours Min.	May 1	1, 1935	Wash.	
ytand M M	10a. State 10b. County	10	Oc. City, Town	n or Location	-				10d. Inside	
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with the Marylar a or 28a-f show be notified at Director	10e. Street and Number			10f. Z	ip Code		1	10g. Citizen of W		
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Examinar must by Funeral	11. Maritel Status  1 ☐ Never Married 2⊠ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  **Dayes 2   No if Yes, Give Year or Detes: 5			2 No	Hispanic Origin? (Sean, Mexican, Puer Specify:	to Rican, etc.)	Blac Specify	k, White, etc.	
er than "natur t, the Medical Completed	15. Decedent's Ed (Specify only highest gra		16a.	Decedent's Us	ual Occup	pation during most of wo	rking	16b. Kind of Bu	siness/Industry	
mple mple	Elementery/Secondary (0-12)	College (1-4or 5+)				during most of wo		II i alexan	Maint	
	10th 17. Fether's Name (First, Middle, Last)			Labo	orer	18. Mother's Na	me (First, Middle	HIGHWA , Maiden Sumam	y Maint	enance
riked off rife ever To Be	Paul Sco					MANAGER A	lma Mi			
The P	19a. Informant's Name/Relationship (		19b	. Mailing Addre	ss (Street				Stete, Zip Code)	20877
er tra	Thelma E. Sco	tt (Wife)							burg, M	
r oth	20a. Method of Disposition  1 XBurial 2 Cremetion 3		20b. Place of cemeter	Disposition (N ry, crematory or	ame of other pla	ice)	Date	20c. Location -	City or Town, State	
lugy o	4 Donation 5 Other (Specify		Emory	Grove	e Cei	metery	1/3/01	Gaith	ersburg	, MD
Sany inj	21. Signature of Funeral Service Liped	Mound	leu			FUNERA Wash. S			, MD 20	850
	23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused the	e deeth. Do	not enter the me	ode of dyi	ng, such as cerdia	c or respiratory a	irrest,	Approxim Interval B	etween
ician									Onset an	d Death
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5				consequence of						
physician end the buriel-trensit the buriel-trensit		D		al Inf		tion			Mini	utes
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for use a		d			HIT				†	
d by the ettendin eteched for use Physician/N	Pert II. Other significant conditions of	ontributing to death but n	not resulting in	n the underlying	cause gi	ven in Part I.	23b. Dtd	tobacco usa cor	ntribute to the caus	e of death?
signed by the e							1 🗆	Yes 2□ No	3 Probably 4	Unknown
hould hould							24a. Was	s an autopsy ormed?	24b. Were autops available pric completion of of death?	or to
i certificate has b lirector, page 2 s							10	Yes 2 No	1 ☐ Yes 2	□ No
ctor, p	25. Was cese referred to medical					26. Place of De	ath (Check only	one)		
0 0	axaminer? 1 Yes 2 No	Hospitel: 1 ☐ Inpatient	2 ER/Ou	tpatient 3 1	DOA Ot	her: 4 Nursing	Home 5 Res	idence 6 Oth	er (Specify)	
meral non:	27. Manner of Death  1 Satural 5 Pending	28a. Dete of tnjury (Month, Dey Y		Time of njury	28c. tnju Wo	ry et ork?	28d. Describe	how injury occurr	ed	
at Director: After the in by the funeral Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		- At home, fa Specify)	m, street, facto		Yes 2 No		(Street and Numb wn, Stete)	er or Rural Route N	umber,
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To the comp	29b. Signeture and title of certifier			2	9c Licen	se number		-	d (Month, Day, Year	)
	1//n B	0			21	1330		12-2	5-00	
7	30. Name and address of person who	completed cause of deat	h (Item 23a)	(Typa, Print)						
	Frank Listello	o, M.D. 9	9901 1	Medica	1 C€	enter Di	r., Roc	kville	, MD 208	50
State	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	4 1	-	Transfer of				



State of Maryland / Department of Health and Mental Hygien 0 42891

					Ce	rtificate	of	Death	1		Reg. N	0.		
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a or 28a-f show	Oire	10e. Straat and Number			4-	10f. Zip	Coda				10g. C	itizan of	What Cour	ntry?
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al', or	by	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	d 1 ☐ Yes if Yas, G Yaar or l	20 No iva		1□ Yas 2	-			, , , ,		Specif		
natur	eted	15. Decedant' (Specify only highest	Education	)	16a. Dace	dant's Usual	Occup	oation	et of work	rina	16b. F	Kind of B	usiness/In	dustry
than "r	Completed	Elementary/Secondary (0-12)		/ (1-4or 5+)	life.	DO NOT use	retire	d)	. or Horn					
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of Haalt filem 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion	3 [ Domesia   1		lace of Dispo			ce)		Data	20c. L	ocation.	- City or To	own, State
ury o		4 □ Donation 5 □ Other (Sp			CONAL	CREMAT	ORY	7		2600	FAI	LS	CHURC	H, VA
Important: If its any injury or o		21. Signature of Furneral Service L	ALL LA		- 3		SK	-GOLI	b OBERO	G MEMOR	IAL	CHA	PEL,I	NC.
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E = 1		27. Mannar of Death	28a. Data		28b. Time of		c. Inju Wo		Jones G. T.	28d. Dascribe				77
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by th	tiffe	3 ☐ Suicida 6 ☐ Could no 4 ☐ Homicide determin	ed 200. Place	e of injury - At ho ling, etc. (Specify	ma, farm, str	aat, factory,	office			28f. Location City or To	(Street e	nd Numi	ber or Rura	al Route Number,
ad in	Certification:	4 LI (10)III030	Dund	ing, etc. (Specify	7					Ony or 10	iwii, Stat	θ)		
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o th	Me	29b. Signature and title of cartifier	. ^			29c.	Licens	a number		1	29d. Da	ata signe	d (Month,	Day, Year)
	-	> kieti	Voh	a M.	P	D2	027	4			DECE	MBEF	17,2	2000
E	-	30. Neme and addrass of person w	no completed co-	se of death /item	23a) /Tune	Print\			_				,	
1		KIRTI VOHRA M.D					ST	PRING.	MD	20902				
Stat	е	31. Deta filed (Month, Day, Year)	32,	Registrar's Signat	-	-								
Registra		DEC 26 2	000	mera	Ø.	Spor	Ka	-						

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Data of Death Dev Month **Physician** 7',30 AM 2000 Marjorie Musicante Schiff 12 20 /Médical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street end number) 4c. County of Death Examiner 11904 Ivahar Street Wheaton Montgomery 5. Social Security Number If Undar 1 Yaar | If Undar 24 Hrs. 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** 1□ M 2\ F Days Hours Yrs. May 22, 577-28-3441 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits r than "natural", or frame 23a or 28a-f ahow the Medical Examples must be notified at Yas 2 No Directo Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 11904 Ivahar Street 20902 United States filed within 72 hours after death Hygiena. other than "natural", or items 23 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Pages 1 and 2 should be filed in nent of Health and Mental Hygis ant: if Itam 27 is marked other 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Jack Musicante Pauline Silberman 19e. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Murray Schiff / Husband 11904 Ivahar St. Wheaton, Maryland 20902 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages Department of Important: If Its any Injury or o 1 XBuriai 2 ☐ Cramation 3 ☐ Removal from State 12/22/00 Mt. Lebanon Cemetery Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Danzansky Goldberg Memorial Chapel, Inc. 1170 Rockville Pike, Rockville, MD 20852 23a. Pert1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Causa (Final disease or condition resulting in deeth) /Medical My ocar D munter Examiner Examiner hewo clerte 10 years the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last attanding physician and I for use as the bunal-tran Physician/Medical Dua to (or as a consequence of): signed by the a Part If. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? should I 24a. Was an autopsy performed? Completed page 2 s is certificate b 1 Yes 2 No 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No 27. Manner of Death 28a. Deta of Injury (Month, Dey Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Panding investigation Injury 1 Yes 2 No 6 Could not be 3 Suicide 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

P.O. Box 68760. Division of Vitai Records.

To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

1 X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

4 Homicide

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State

Registrar

unit) Wensfrle

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30. Nama and address of person who complated cause of death (Item 23a) (Type, Print)

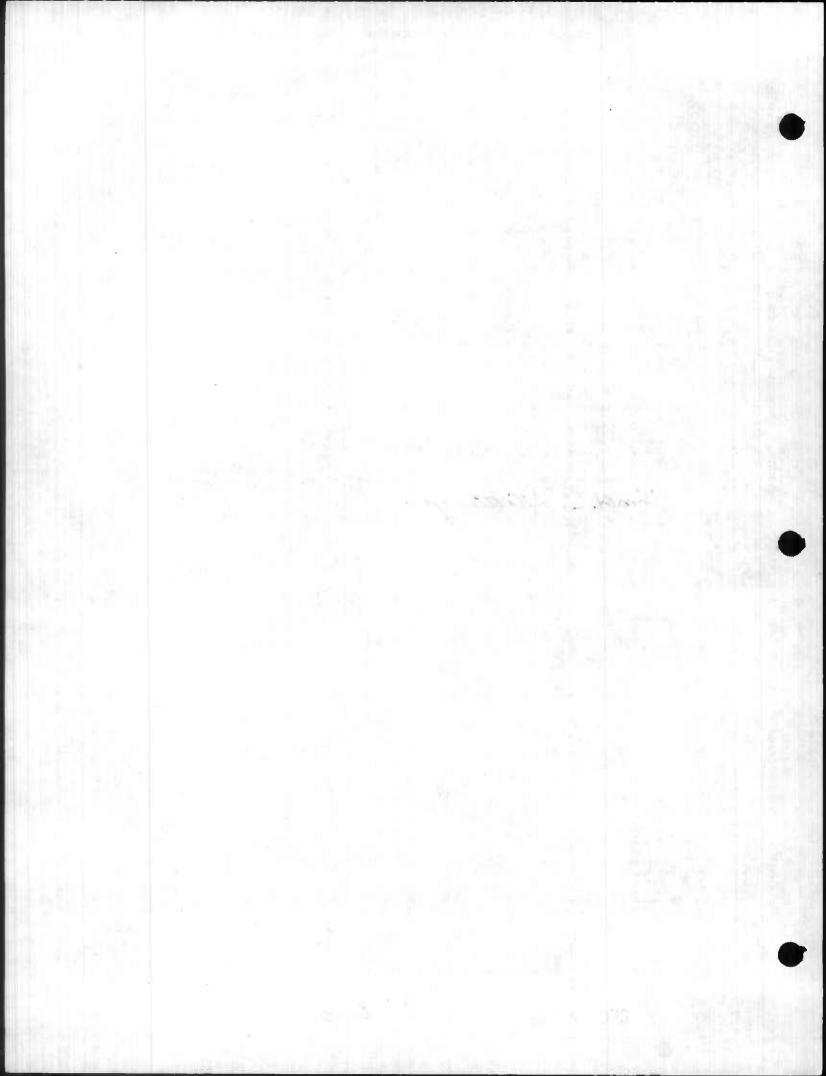
10313 Georgia Ave. #105 Alan Weinstock

31. Date filed (Month, Dey, Year)

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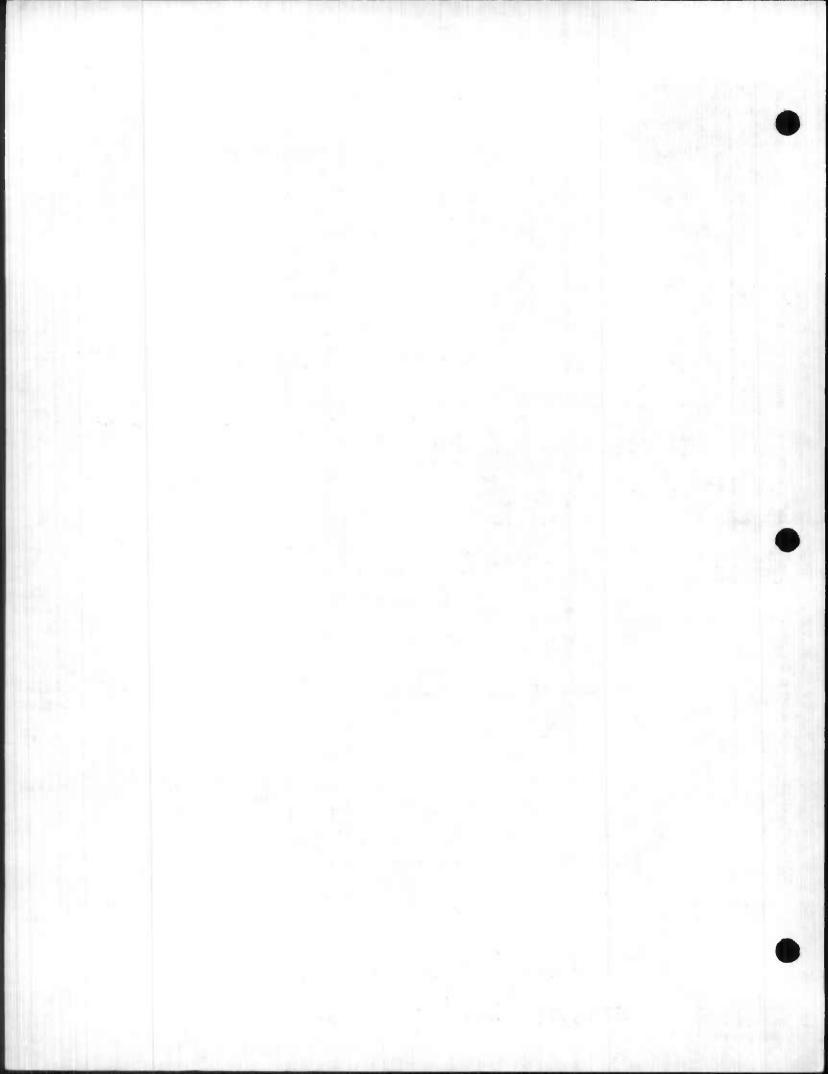
32. Registrar's Signatura neres

Silver Spring, MD 20902



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (Fit	st, Middle, Last	)		Cei	tificate of	Dealii	2. Data of D	Reg. No.	42	C O 2
Physician	Doris		0		Schi	f f		Month Dec.	23 200	Year	10:25 AM
/Medical	4a Facility Name (If not	institution, giva	street and number	or)	SCIII		4b. City, Town, or			_	10.23 AF
Examiner											
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Funeral Director	055-16-11 Usual Residence of Dec	.55	о́м 2∰ F	nge (III yis.	79 <sup>Yrs.</sup>	Months Days		(Month, D	ay, Year)	New Y	a (State or Forei Ork
death with the Meryland THE 23s or 28s-1 show THEST OF ECUTED ST	10a. State 10b	. County		10c. Ci	ty, Town or Loc	cation				10d.	Inside City Limit
recto	MD	Montgon	nery	Ro	ockvill.	е					1√ Yes 2□N
or 28a-1 al	10e. Street and Number					10f. Zip Code			10g. Citizen of W	/hat Country	?
234		roce As				208	252		United	Stat	0.0
home:	11. Marital Status	TOBE IIV	12. Was Deceder	nt Ever in U	J,S. 13. V	as Decedent of	Hispanic Origin? (5	pecify Yes or N	o- 14. Race	- American	Indian,
0	1 Never Married		Armed Force 1  Yes 2  If Yes, Give Year or Date:	0 No		Yes, specify Cu	ban, Mexican, Puer Specify:	to Hican, etc.)	Specify.	k, White, etc	
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To E		Could not be determined	28e. Place of I building,	njury - At h atc. <i>(Specil</i>	ome, farm, stre	et, factory, office			(Street and Number own, State)	er or Rural R	oute Number,
within 24 hours. To the Funeral completaly filled	29a. Certifier 1 (Check only one)	Certifying Phys Medical Examin	sician: To the besis ner: On the basis and manner:	of examina	owledge, death ition and/or Inve	occurred at the testigation, in my	time, date and place opinion, death occu	e, and due to the urred at tha tima,	cause(s) and ma data and place, a	nner as state and due to th	ed. a cause(s)
omp omb	29b. Signature and titte of	f certifier	*			29c. Licer	ise number		29d. Date signed	(Month, Day	y, Year)
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	30. Name and address of	person who co	1 . 2				0 1	.11	4		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend Item 26, verbal respons State of Maryland / Department of Health and Mental Hygiene 12/27/2000, Carroll County, wj1 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Deeth 3 Time of Death DECEMBER 25, **Physician** CATHERINE HARRIET TRAVIS 2000 9:00 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** COUNTRY COMPANIONS TANEYTOWN CARROLL If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Sociel Security Number 6 Sex 7. Age (in yrs. lest birthday) 8. Dete of Birth (Month, Dev. Year) SEPT 30, 1920 9. Birthpiece (State or Foreign **Funeral** 1□M 2\ F 204-30-2229 80 VIRGINIA Director Usuei Residence of Decedent 10b. County 10c. City. Town or Location r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits PA **ADAMS** CARROLL VALLEY Director 1 Nes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11 ASPEN TRAIL 17320 U.S.A. Funeral daath 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No 11 Maritei Stetus 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - American Indien. filed within 72 hours after 1 Never Merried 2 Merried Specify: WHITE Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: If Yes, Give Yeer or Detes: þ 3 DWidowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) SALES PERSON 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementery/Secondery (0-12) Coilege (1-4or 5+) FOOD DIST. permit. Pages 1 and 2 should be filed wit Department of Health and Mantal Hygiens important: if them 27 is marked other that only injury or other trearmetic event, the once. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) ROYAL JAMES MCINTOSH GERTRUDE MCCLAIN 19e. Informent's Neme/Reletionship (Type, Print)
KAREN SUTCH / DAUGHTER 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) CARROLL VALLEY, PA 17320 11 ASPEN TRAIL 20b. Piece of Disposition (Name of 20e. Method of Disposition DEC 27 20c. Location - City or Town, Stete 1 X Buriei 2 ☐ Cremetion 3 ☐ Removel from Stete EMMITSBURG MEMORIAL CEM EMMITSBURG, MARYLAND 2000 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Neme end Address of Fecility SKILES FUNERAL HOME M00534 EMMITSBURG, MD 21727 210 WEST MAIN STREET 23a. Pent/Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Death Physician immediate Ceuse (Finel disease or condition resulting in deeth) /Medical hronic 184 Examiner Due to (or es a consequence of): Physician/Medical Examiner attending physician and for usa as the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Due to (or es e consequence of): P.O. ed by the e Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown aschla Division of Vital Records, Š should l 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy perlormed' page 2 s 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifica staly filled in by the funeral director, Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Assisted Other: 4 Nursing + Hospital: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 10 1 Yes 2 No me 5□ Residence 6 MOther (Specify) Living 27. Manner of Death 28e. Dete of tnjury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28c. tnjury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 8 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pieca of injury - At home, ferm, street, fectory, office building, etc. (Specify) To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pieca, end due to the cause(s) end menner steted. 29e. Cartifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

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31. Dete filed (Month, Dey, Year)

DEC 2

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Philip Kon its, m. 15

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32. Registrar's Signeture

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State

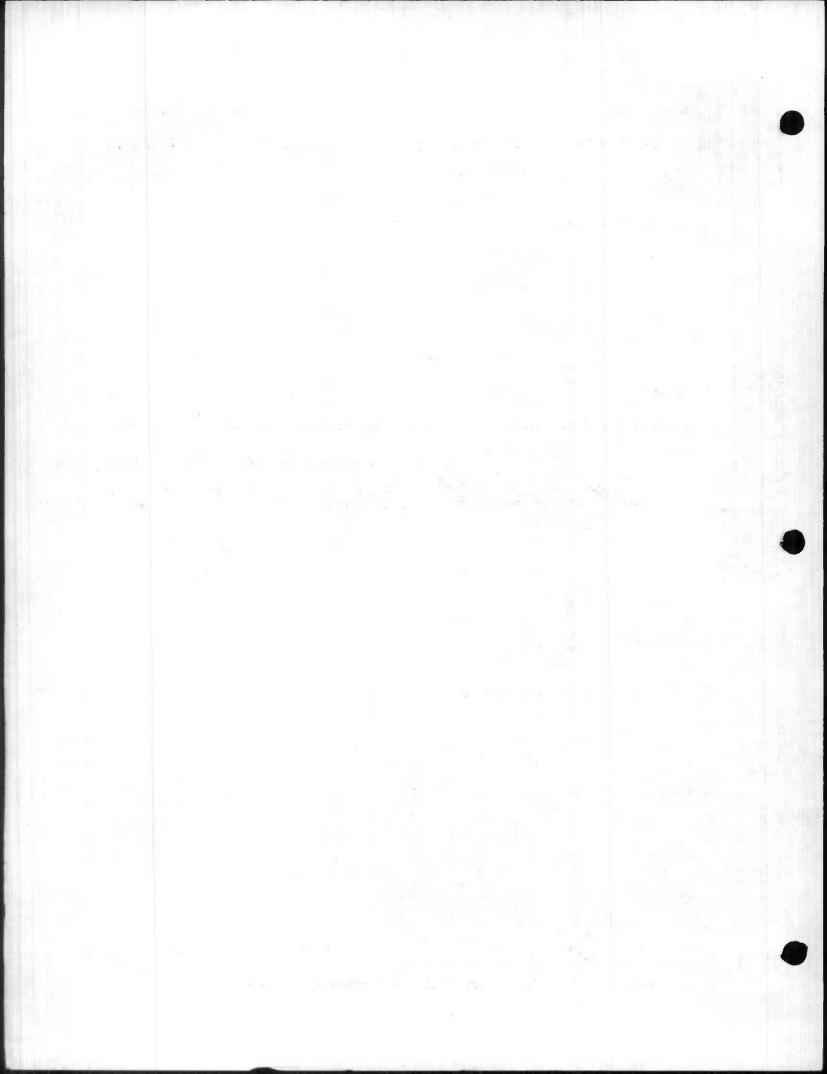
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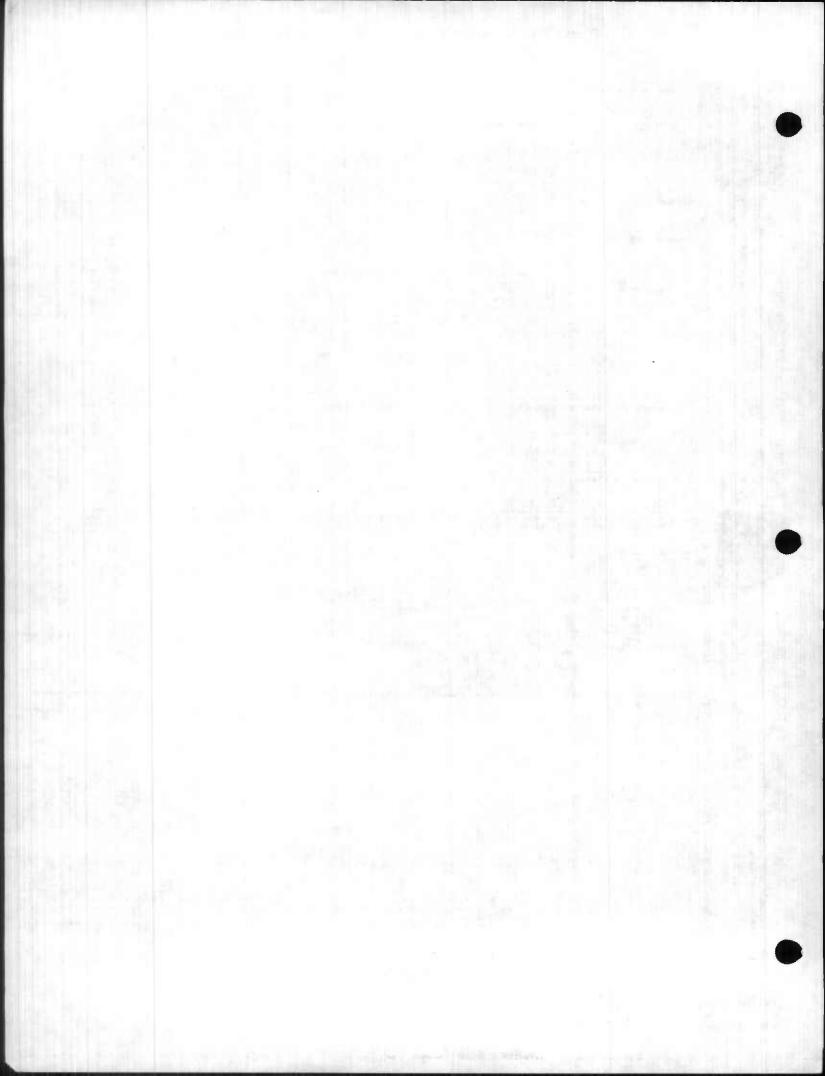
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Certificate of Death

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perent filed in by the funeral director, page 2 should be deteched for use as the buriektransit  a policy  cellical Certification: To Re Commissed by Dhyskilan Medical Examiner	medical continued by respect of the second s	Immediate Ceuse (Final disease or condition resulting in deeth)  Sequentially list condition if any, leeding to immadiate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Lest  Pert II. Other significant  25. Was case referred to examiner? 1   Yes   2   X No  27. Manner of Death 1   X Naturei   5   2   Accident 3   Suicide   6   4   Homicide  29a. Certifier (Check only one)	ons, liate  conditions of the	a.Senile b. c. d. 28e. Dete contributing to de cont	Demen Due to (  Due to (	or es e consector as a consector as	Quence of) quence of) quence of) quence of) quence of) mut 3 D f M reat, factor	Cause give	en in Pert I.  26. Piece er: 4\( \) Nui y at k? Yes 2 \( \) No. ine, dete encoinion, deat	of Death sing Hom 2 lo	23b. Did to 1 Y  24e. Was a perfor  1 Y  (Check only or Town  8f. Location (S  City or Town  and due to the code of the time, do	est,  becco use co  es 2Ñ No  en autopsy med?  es 2 No  ne) enca 6 Ott  ow Injury occur  treet end Numi n, State)  euse(s) end mate end place,	ontribute to  3 Prob  24b. We eva com of d  1 Deer (Specify red)  ber or Rurel  enner es ste and due to ed (Month, E	Approxime Interval Be Onsat and 5 ye.  the cause ably 4 [ re autopsy lieble prior ppletion of leeth?  Yes 2 [ )  Routa Nur beted. the cause ably 2 [  Routa Nur beted. The cause ably 2 [  Routa Nur beted. The cause ably 2 [  Routa Nur beted. The cause ably 3 [  Routa Nur beted. The cause ably 3 [  Routa Nur beted. The cause ably 3 [  Routa Nur beted. The cause ably 3 [  Routa Nur beted. The cause ably 3 [  Routa Nur beted. The cause ably 3 [  Routa Nur beted. The cause ably 3 [  Routa Nur beted. The cause ably 3 [  Routa Nur beted. The cause ably 3 [  Routa Nur beted. The cause ably 3 [  Routa Nur beted. The cause ably 3 [  Routa Nur beted. The cause ably 3 [  Routa Nur beted. The cause ably 3 [  Routa Nur beted. The cause ably 4 [  Routa Nur	of death finding causa

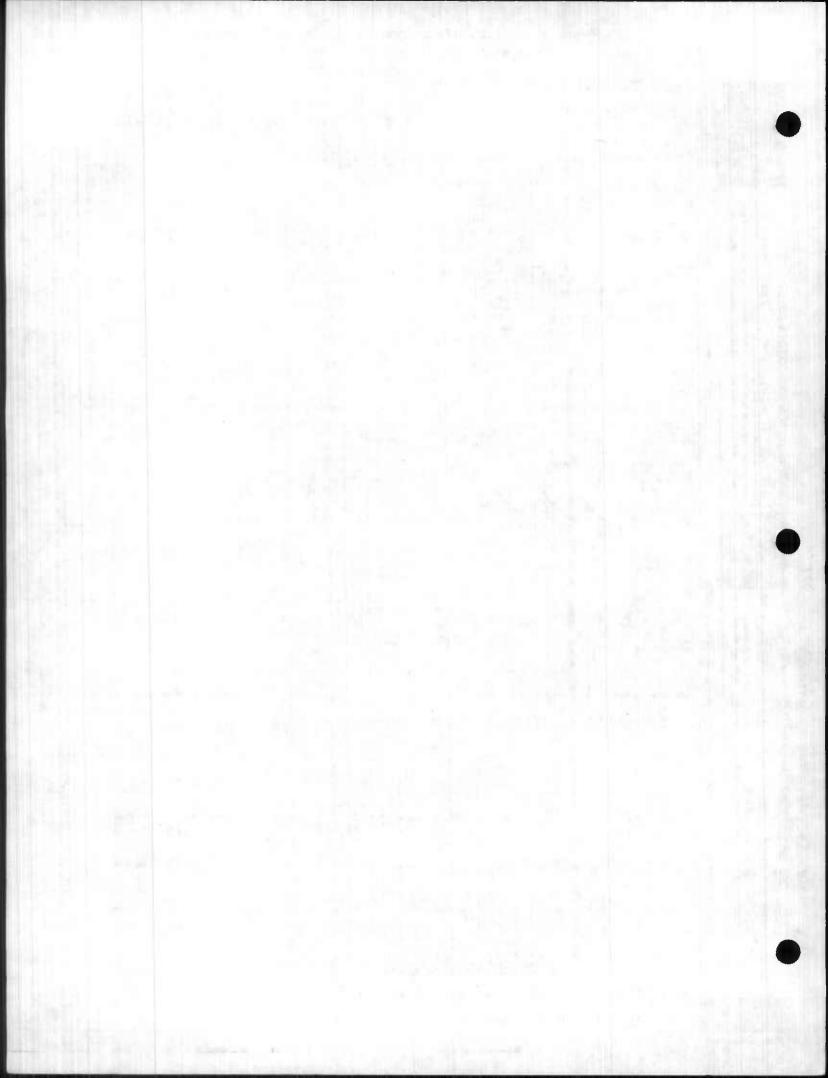


Ì			State of Marylan	Certifica				Reg. No.	) 4	2896
		1. Decedent's Name (First, Middle, Last)					2. Dete of De Month	eth Dev	Yeer	3. Time of Death
	Physician	Bernard E. Tucker						,		5:00 pm
	/Medical Examiner	4a Fecility Neme (if not institution, give	street end number)			4b. City, Town, or l				3.00 pm
	Funeral	Holy Cross Hospita  5. Sociel Security Number 6. Sec	1	Month	er 1 Yeer	Silver SI If Under 24 Hrs. Hours   Min.	oring 8. Data of Bir (Month, De	Montgo	omery 9. Birthplac	ce (State or Foreign
ш	Director	577-09-5036	82 82	Yrs.				0, 1918		
	2	Usual Residence of Decedent	40- 0%						1404	
	ahov a	10a. Stete 10b. County	Toc. On	y, Town or Location					100	I. Inside City Limits
	cto cto	Maryland Montgomer	y Whe	aton						1 ☐ Yes 2 ☐ No
	or 28s-f a	10e. Street and Number		10f. Z	ip Code			10g. Citizen of W	/het Country	17
	h wi	3302 Harrell Stree	t	209	906			USA		
	ifter deeth with the Menylan r Herre 23s or 28s-f show infer must be notified at Funeral Director		12. Wes Decedent Ever in U,	S. 13. Was Dec	edent of h	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No	- 14. Race	e - Americen	
Maryland 21215-0020	urs al		Armed Forces?  1 ☑ Yes 2 ☐ No  If Yes, Give  Yeer or Detes: WWII	1 □ Yes		Specify:	o Rican, etc.)		k, White, etc Whit	
0	ed within 72 hours ygiene. er than "natural", t, the Medical East t, the Medical East Completed by	15. Decedent's Edu		16a. Decedent's Us	uel Occup	pation		16b. Kind of Bu	sinass/Indus	stry
15	c . W =	(Specify only highest grade Elamantary/Secondary (0-12)		(Give kind of w	vork done use retire	during most of wor	king	Chesape	eake &	Potomac
217	Hygiene.  Hygiene.  ont, in the	12	College (1-4or 5+)	Installer	·/ Re	pairman		Telepho	one	
D	ET & E	17. Father's Neme (First, Middle, Last)			,	18. Mother's Nen	ne (First, Middle,			
an	0 2 D 6 W	Thomas S. Tucker				77 - 4-1	- M D-	. 1		
7	should not marke umarke	19a. Informent's Neme/Reletionship (Ty	ne Printl	19b. Meiling Addre	es (Street	Katherin			State Zin C	oda)
Ma	0									oday
	f Heelth frem 27 other tr	Dorothy M. Tucker  20e. Mathod of Disposition		3302 Hari			Wheaton,	MD 209 20c. Location -	906 City or Town	Clate
0	8 5 2 0	1X Buriel 2 Cremetion 3 R	emovel from Stete	Plece of Disposition (Nemetery, cremetory or	other ple	ce)	Date	200. Location -	City of Yow	1, 31616
E	Part: neury nury	4 □ Donetion 5 □ Othar (Specify)		e of Heave	en Ce	metery	12/28/00	Silver	Spri	ng, MD
Baltimore,	permit. Page Department of Important: If any Injury or page.	21. Signature of Funeral Service License	90			ss of Fecility	T 1	TT	T	
0	Dep du A	Khow or & &	hole			Collins				MD 20001
		23a. Pert1 Enter the disease, or complishock or heart teilure. List only or	cations thet caused the deet	h. Do not enter the mo	ode of dvir	SILY BIVE	or respiretory e	rest.	. A	MD 20901
	Physician /Medical	Immediate Cause (Final	na causa on each ne.  Congestive H						0	ntervel Between Onset end Death
•	Examiner	resulting in death)		r es e consequence o					1	
Н	executed n and ial-transit		Coronary Art	ery Diseas	92				5	years
	to be executed sicien and burial-transit	Sequentially list conditions,		r es e consequence o						10010
o o										
68760,	cata be executed physicien and sthe burial-transit	Cause (Disaase or injury that initieted events	Due to (o	r es e consequence of	):					
89	= 0	resulting in deeth) Lest								
Вох	use use		1.							
m	at the death certific d by the attending patached for use as Physician/Me	Det II Other significant conditions are	Aribution to death but and one	ulation in the constant in a		en in Dod I	Oah Did	tehana was ann	ntelbute to t	he cause of death?
0	ed by the datached	Pert II. Other eignificant conditions con	ithouting to death but not res	uiting in the underlying	ceuse gr	en in Pen I.				
Q.	igned by be data by Ph	Chronic and Acute	Renal Failure				10	Yes 2 XNo	3 Proba	bly 4 Unknown
Records,	5 5 A						24s Wes	en eutopsy	24h Wers	autopsy findings
0	The law require sete has been single 2 should I	Insulin Dependent	Diabetes Mell	itus Type	2			ormed?	eveite	ebte prior to pletion of cause
ec	has by ye 2 s								of de	alh?
E .	The I	Hypertension					10	Yas 2 No	101	Yes 210 No
Vital	s certificate director, pag To Be Co	25. Wes cesa raferred to medical exeminer?				26. Place of Dea	th (Check only	ona)		
2	5 90	1 Yes 2 No	lospitel: 1X Inpatient 2	ER/Outpatient 3 1	OOA Oth	ner: 4 Nursing H	lome 5 ☐ Rasi	dence 6 Oth	er (Specify)	
100	erth nerel	27. Mannar of Death	28a. Deta of Injury (Month, Dey Year)	28b. Tima of Injury	28c. Inju	ry et	28d. Dascribe	how injury occurr	red	
0	oth. :: After e funer	1 ☑Neturet 5 ☐ Pending investigation	(Morali, Day Tour)	M		Yes 2 □ No				
Division	to or Attending P rs effer deeth. at Director: After t led in by the funeral Certification:	3 Suicide 6 Could not be	28e. Plece of Injury - At ho	oma, farm, street, facto	ory, office		28f. Location (	Street end Numb	er or Rurel f	Route Number,
á	Per din Per e	4 Homicida	building, etc. (Specify	y)			City or To	wn, Stete)		
	Hospi 4 hour Funer tely fill	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the bast of my kno- ner: On the basis of examine end menner steted.	wledge, deeth occurre tion end/or investigation	d et the ti	me, data end plece prinion, deeth occu	, end due to tha irred at the time,	cause(s) and ma date and place, o	inner as stat end dua to ti	ted. he ceuse(s)
	within 2 To the comple	29b. Signature and Me of certifier	. ()	2	9c. Licens	se number		29d. Date signed	d (Month, De	ay, Year)
		1. 1.	111 4	0	n 00	700		D	. 00	2000
	12	med	Me, M.	. 0	D 03	192		Decembe	er 26,	, 2000
		30. Neme and eddress of person who co	Control of the contro							
			10301 Georgia		aton	MD_2090	2			
	State	31. Dete tited (Month, Day, Year)	32. Registrer's Signe	rure A	ach	,				



State of Maryland / Department of Health and Mental Hygiene 0 428

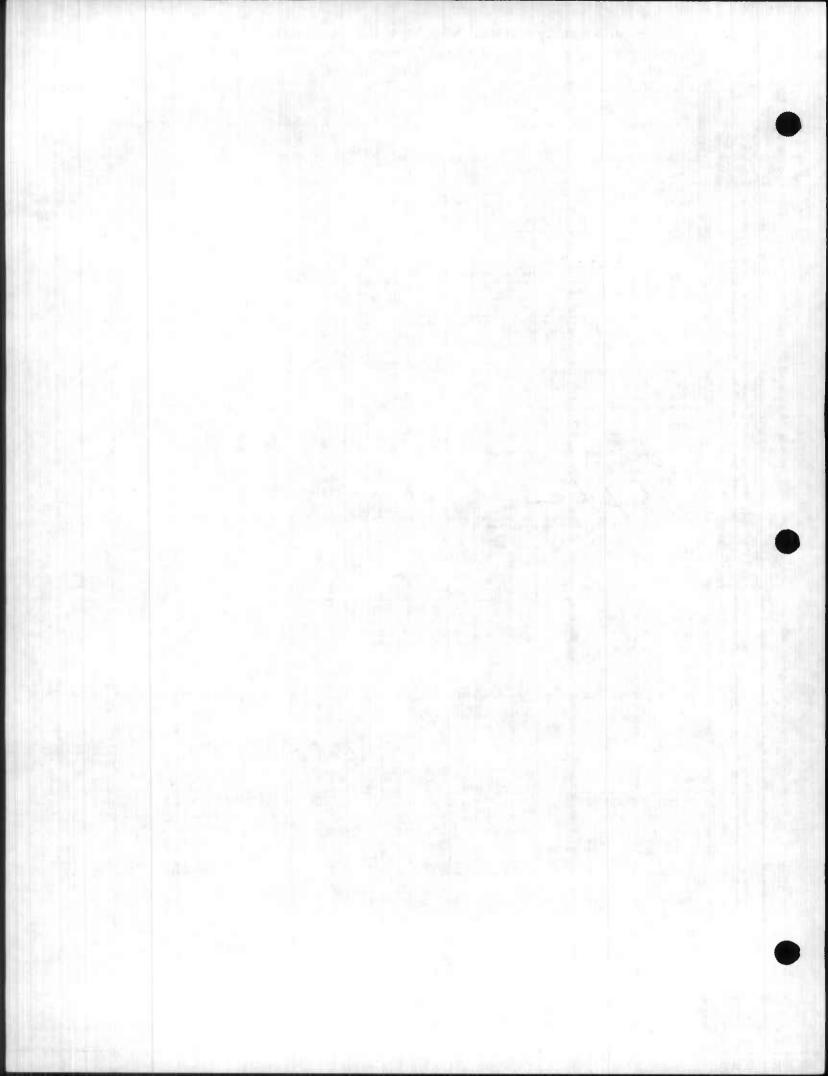
			in build	,	Cei	rtificate of	Death		Reg. No.	) 4	6091
	Dhualalau	1. Decedent's Name (First, Mid	ldle, Last)					2. Date of Do	eath Day	Year	3. Time of Death
-	Physiciar /Medica	leanne M Trea	nor					Dec embe	01 001		2:55 PM
	Examine	4a Facility Neme (If not institut		m <i>ber</i> )		7617		or Location of Dee	th 4c. Count	y of Deeth	
		Suburban Hospi	tal				Bethesda		Montg	omery	
н	Funeral Director	5. Social Security Number 559 10 0780	6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs.	last birthday) 34 Yrs.	Months Days		in (Month D	rth ay, Year) 4,1916	Cour	olaca (State or Foreign olty) fornia
	yland how Lat	Usual Residence of Decedent  10a. State 10b. Coun	ty	10c. Ci	ty, Town or Lo	cation				1	Od. Inside City Limits
	h the Maryla yr 28a-f sho e notified at	Maryland Mont	gomery	Ker	nsingto	n					1 ☐ Yes 2t No
	or 28a-f	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	itry?
			d Road	4.3.44 T		20895	170-07		USA		
Maryland 21215-0020	at, or there 23 Examiner must	3 □ Widowed 4 □ Divorce	Armed Fo	2 🖾 No ve		Was Decedent of If Yes, specify Cul 1□ Yes 2점 No		(Specify Yes or Nerto Rican, etc.)		ce - Americ ack, White, <sup>fy:</sup> Whit	etc.
9-9	72 ho	15. Deced	ent's Education nest grade completed)		16a. Deced	dent's Usual Occu kind of work done DO NOT use retin	pation	vorkina	16b. Kind of E	Business/In	dustry
2	In the state of th	Elemantary/Secondary (0-12		1-4or 5+)			ed)	on any			
2	led within typiens.  The Men of t	12			Home	maker			Own H		
Pu	2 1 2 2 2	17. Fetner's Name (First, Middl	e, Last)				18. Mother's N	lame (First, Middle	e, Maiden Suma	me)	
y s	Men Men Men Men Men Men Men Men Men Men	Edward Palmer						e Lamey			
Aar	2 sh Faring	19a. Informant's Name/Relatio						Rural Route Numi			
	Hem 27	Merry E. Trean	or / Daugh					Kensingt			
Baltimore,	Pages ment of P ant: If he lury or of	20a. Mathod of Disposition  1 Burial 2 Cremation  4 Donation 5 Other		Siate	tropol:	esition (Name of matory or other pla itan Cre	matory	December 28,2000	20c. Location Alexan		Virginia
Bal	Departiment important impo	21. Signature of Funeral Service	School School	200	F		Collin	ns Funera			ryland 20901
		23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that	aused the dee							Approximate Intervel Betwaan
	Physician	SHOOK, OF HOUR INITIAL E.									Onset and Death
Z	/Medical	Immediate Cause (Final disease or condition	NOI	V-SM	A1.2	CFLLI	11/1/6	CARC	INOM.	4	12 MONTH
SSH	Examiner	resulting in death)	a		or as a consec						
2	D # 5		<b>a</b> b							-	
0	and -trans	Sequentially list conditions,		Due to (	or as e consec	quance of):		164 -			
0 %	be an iclan buria	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or Injury	2 0								
68760,	filests be assecuted applysician and as the burist-transit	that initiated events resulting in death) Last		Due to (	or as a conseq	uenca of):				t	
(6/ (6/	- OH -		d								
10/10/0/00 O. Box	sien: The law requires that the death certificate has been signed by the attending rotor, page 2 should be detached for use as Re Complexed by Dhysician Mar							ant Di-			
_	by the ptached	Part II. Other significant condi	- 0			ndenying cause g	Iven in Part t.				o the cause of death?
4	igned be deta	OBSTRUCTI	IE PIVEL	MONI	A				) 188 ZLI NO	3   10	oubly 4 markiowii
JEANN G Vital Records,	been significant been significant been significant been significant been significant been significant been significant been significant been significant been significant been significant been significant been significant been significant been significant sig							24a. Wa	s an autopsy	24b. W	era autopsy findings
> 3	v requ						10.00	pen	formed?	00	vailable prior to empletion of cause death?
JEANN I	yaiclen: The law is certificate hes b director, page 2 s							45	W. 05%		
E E	certificate irector, pag	OF Management and to made					-2.01		Yes 2000	11	Yes 20 No
5 5	- 3 - 6	25. Was case referred to medic examiner?	Hospital:	/	Tento : :		Whor:	Death (Check only			4.0
00	E E = -	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 11		28b. Time of	1 3LI DOA	4 LI Nursin	Homa 5 ☐ Res 28d. Describe	how injury occu		<i>y)</i>
	After fune	1 Natural 5 Pend	ding (Mon	of Injury th, Day Year)	Injury	W	ork? □Yes 2□No				
≥ is	Attending or death.	2 Accident Invest	d not be	of thiury - At h	nome farm str	eet, factory, office		28f. Location	(Street and Nun	ber or Run	al Route Number,
EHNO) Division	after deat Director: J in by the	4 Homicide data	rmined 288. Place build	ing, etc. (Speci	ity)	out, lactory, omo		City or To	own, State)		
\	portal dillo	29a. Certifier 1 Certifi	ring Physician: To the	best of my kno	owladga, death	n occurred at the	time, date and pla	ace, and dua to the	cause(s) and n	nannar as s	stated.
	To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	(Check only 2 Medic	at Examiner: On the b								
	Vithin Vithin Comp	29b. Signature and titla of certi	fier			29c. Licer	nse number		29d. Date sign	ed (Month,	Day, Year)
		1/1/1/16	Hayan n	12		023	308		DEC.	27	2000
	3	30. Name and address of perso	on who completed caus	se of death (Ite	m 23a) (Type.	2010	30				
		VICTOR PRIE		6410 R		OF DR.	# 625	BETHE	SDA, N	102	0817
	State	31. Dete filed (Month, Day, Yea		Registrar's Sign	ature _				- //	-	
	Registrar	DEC 28	2000	merces	B.	pour	1				



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

				Cer	tificate of	Death			Reg. No.		2000
	1. Decedent's Neme (First, Middle,	Last)						2. Data of Do Month	eath Dey	Yeer	3. Tima of Death
Physician /Medical	F. Gerald	Toye						Decemb			11:40 PM
Examiner	4a Facility Name (If not institution,	giva street and n	um <i>ber)</i>			4b. City, To	wn, or Lo	cation of Deal	th 4c. County	of Death	
	414 Russell Av	enue				Gaith	hersb	urg	Montg	omer	у
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Yea	r If Under:			rth	9. Birth	pleca (Stete or Foreign
Director	074-03-4639	1፟፟፟∭M 2□F	95	Yrs.	Months Dey:	s Hours	Min.	October	15, 1905 1	New	York
	Usual Residenca of Decedent	54217									
Su Bu	10a. Stete 10b. County		10c. City	, Town or Lo	cation				nor Ess		10d. Inside City Limits
Man Hed	Maryland Montg	omery	Gai	ithers	burg						1 X Yes 2 □ No
or 28s-fr be notifie Directo	10e. Street and Number				10f. Zip Code				10g. Citizen of W	/het Cou	ntry?
	414 Russell Av	onile			20877	7			United	Stat	- 6 5
her death hiner thems 23 siner must	11. Marital Status		cedent Ever in U.	S. 13. V	Was Decedent of f Yes, specify Cu		igin? (Spe	city Yes or N		- Ameri	can Indien,
5 28 5	1 Never Married 2 Merrie	Armed F	orces?				n, Puerto F	Rican, etc.)	Blec	k, Whita,	etc.
5-0020 72 hours after natural; or for digest Examine etcd by Fu	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Yeer or	ive		1□ Yes 2∏ No	Specify:			Specify.	WI	nite
O S P	15. Decedent's			16e. Deced	ient's Usual Occi	upation			16b. Kind of Bu	siness/In	dustry
1215	(Specify only highest			(Give	kind of work don DO NOT use retir	e <i>during</i> mosi <i>ed)</i>	t of workir	ng			
1 21215-0 ed within 72 ho system. we then 'nature it, the Medical. Completed	Elementary/Secondery (0-12)	5-	(1-4or 5+)  -		Lawyer				General	Ele	ectric
D THE D	17. Father's Nema (First, Middla, L					18. Mothe	er's Neme	(First, Middle	, Maiden Sumem	e)	
ylanc wid be it Mental H Mental H Mental H To Be	Samuel Toye					Carr	rie J	ones			
To To	19e. Informent's Name/Relationsh	in (Type, Print)		19b. Meilir	na Address (Stree	et and Numbe	er or Rura	I Route Numl	ber, City or Town,	State, Zi	p Code)
Maryland 21215-0020 at 2 should be lited within 72 hours at the and Mental Hygene. It is marked other than "natural", or traumatic event, the Medical Exami To Be Completed by F	Anna F. Toye/Wi								ourg, Mai		
	20e. Method of Disposition	1.0	20b. P	1	sition (Neme of	TVCIIGO	, 04.	Dete	20c. Location -		-
Pages hert of ary or o	1 Burial 2 Cremetion		State	ametery, cren	netory or other pi		p	cember			
The state of the s	4 □ Donation 5 ☒ Other (Sp		ent Par		Memoria:			, 2000	Rockvill	Le, I	Maryland
Baltimore, semit. Pages 1 a bepartment of Hear reportant: If Nem key Injury or othe bits.	21. Signeture of Funeral Service L	cansee		Rol	Name end Add	ress of Fecilit Limphrev	y Funer	al Home	/Rockville	e. In	c.
m 9074a	Karf Fre		M0019								nd 20850-2805
	23a. Pert1. Enter the disease, or of shock, or heart feilure. List of	omplications that	caused the deeth	. Do not ent	er the mode of dy	ying, such as	cardiac o	r respiretory	arrest,	-	Approximete Intervel Between
Physician										1	Onset end Daath
/Medical	Immediate Ceuse (Finel disease or condition	Is	schemic :	Leg							2 Weeks
Examiner	resulting in deeth)	θ		r es e conseq	juence of):						
e e		At	heroscle	erosis							Years
OX 68760, certificate be executed viding physician and use as the burial-transit and wheelical Examiner	Sequentially list conditions	b	Due to (or	r es a conseq	juence of):						
exe an ar nial-trial-tr	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury										
68760, ifficete be exe g physician a es the burial-	that initiated events	C	Due to (or	as e conseq	neuca ot):		-			-	
Box 6876 death certificete by attending physic of for use as the biclar/Medica	resulting in death) Last	- L 1 1 3	200 10 (0)	40000000	301104 07						
Certification of the control of the		d									
that the death certed by the attending detached for use	Death Other leading and an adult		4.50.5.4.4.4	Maria ta Maria	4.4.1.	- Lunda Dawl		ogh Die	l tabassa usa san	a deal deal of the	to the cause of death?
the day the ached	Pert II. Other significant condition										
S, P. as that the igned by be detacted by Phy	Ischemic Heart	Disease	, Chroni	c Obst	ructive	Pulmo	nary	1	Tes 250 No	3   FR	obably 4 Unknown
Records, he lew requires the has been signed age 2 should be dompleted by								24a. We	s en autopsy	24b. V	Vere eutopsy tindings
v require been si should l	Disease, Dement	ia							ormed?	6.	veilable prior to ompletion of cause
The lew requir										0	f death?
= F # 0								10	Yes 2NNo	1	Yes 2 No
of Vital F Physician: The this certificate rel director, pag. To Be Co	25. Wes case referred to medical examiner?	11 71				111111111111111111111111111111111111111	e of Deeth	(Check only	one)		
Physic this c rel direction T. To	1∑ Yes 2□ No	Hospitel: 1	Inpatient 2	ER/Outpatier	IT 3LI DUA			A.b.	sidenca 6 Oth		ify)
ding Ph h. After th funerel	27. Manner of Death 1 ☑ Neturel 5 ☐ Pending	28a. Dete (Mo	of tnjury nth, Dey Year)	28b. Time of Injury	28c. Inj	ork?	1	28d. Describe	how injury occur	ed	
Attending or death.  octor: Afte by the fune iffication	2 Accident investige	etion			M 1	Yes 2					
Division or Attending after death. Director: After d in by the fune ertification	3 Suicide 6 Could no determine	red 286. Plec	e of Injury - At ho	me, farm, str	eet, factory, offic	a	3		(Street end Numb own, Stete)	er or Ru	ral Route Number,
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boundary fill hy fill cai									cause(s) end me		
he Hospi in 24 hou he Funer pletely fill edical	one) 2 medical E	and me	nner steted.	ion endor in	vestigation, in my	opinion, dee	SUI OCCUITI	ed at the time	, date end place,	2110 000	10 (110 00000(3)
Divisor  To the Hospital or Attention 24 hours after de within 24 hours after de To the Funeral Directo completely filled in by the Medical Certific	29b. Signature and title of certifier	7 11	0 -	-	29c. Lice	nse number			29d. Date signed	d (Month	, Day, Year)
	1 Stul	4 VIII	luch	in	D1	9294			December	r 26	, 2000
25	30. Name and address of person w	ho completed cau	use of deeth (Item	23e) (Type,							
	John R. Melnick					aither	sbur	g, Mar	yland 20	879	
State	31. Dete filed (Month, Dey, Year)		Registrer's Signe		-						
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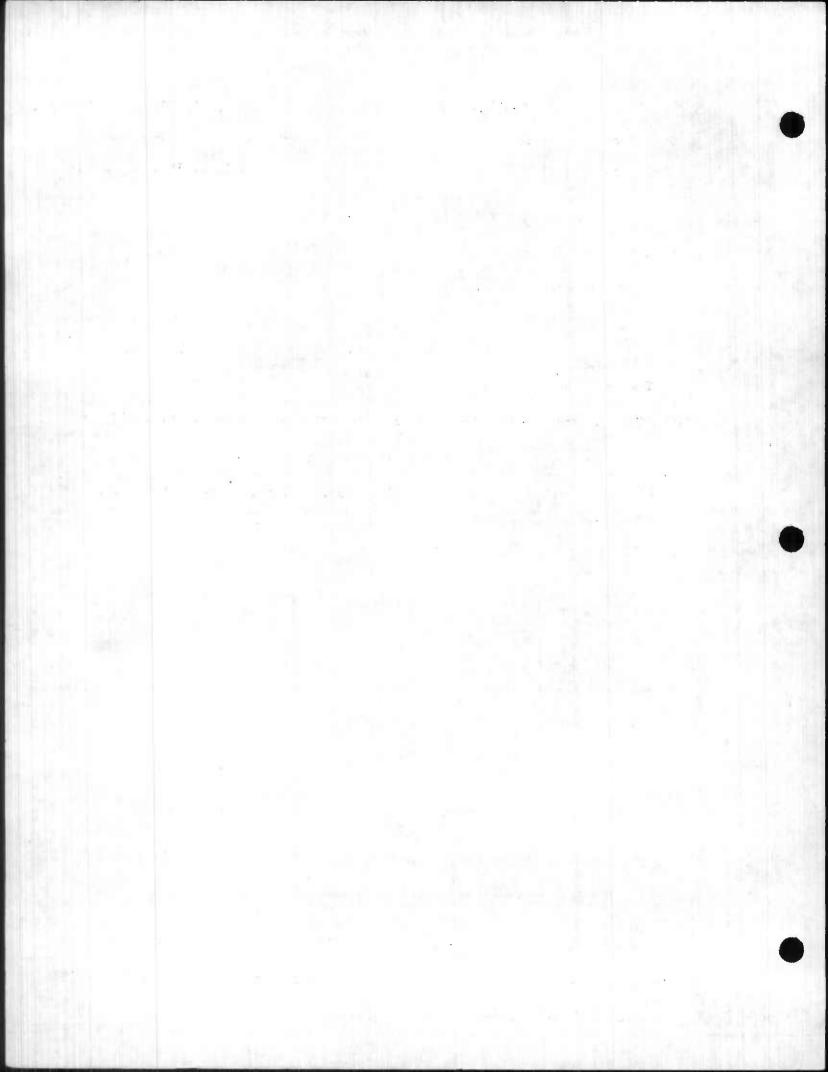
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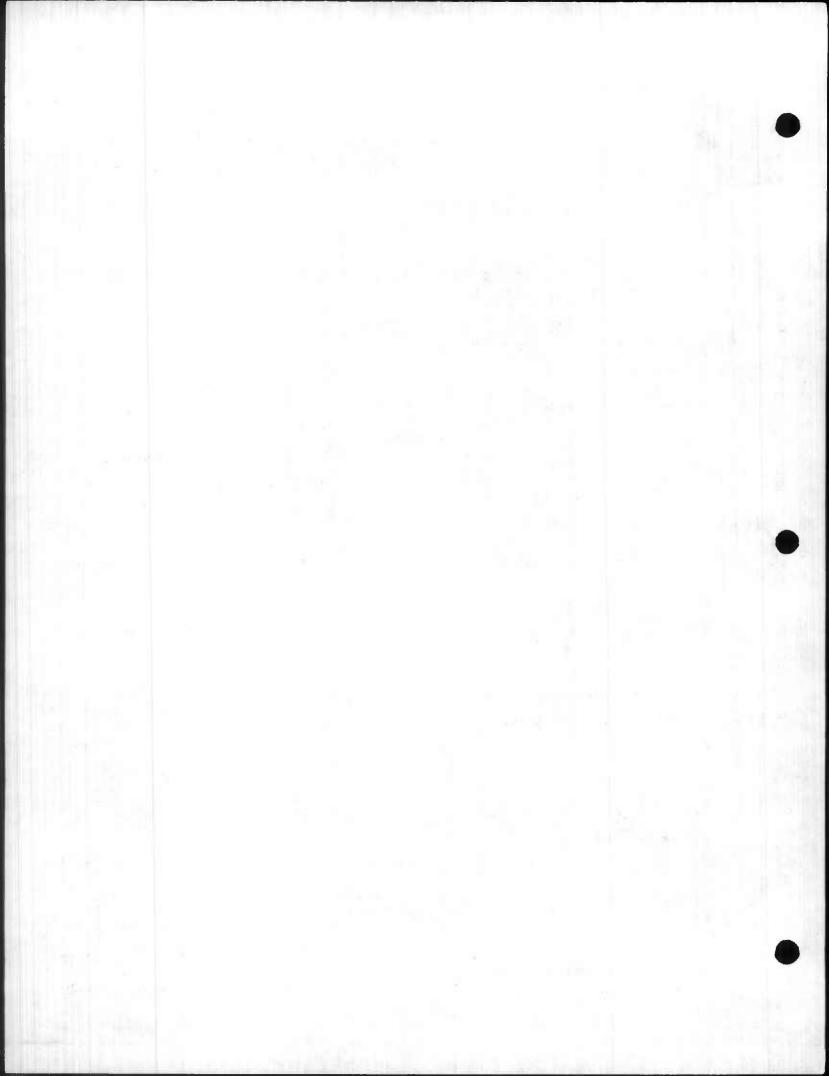
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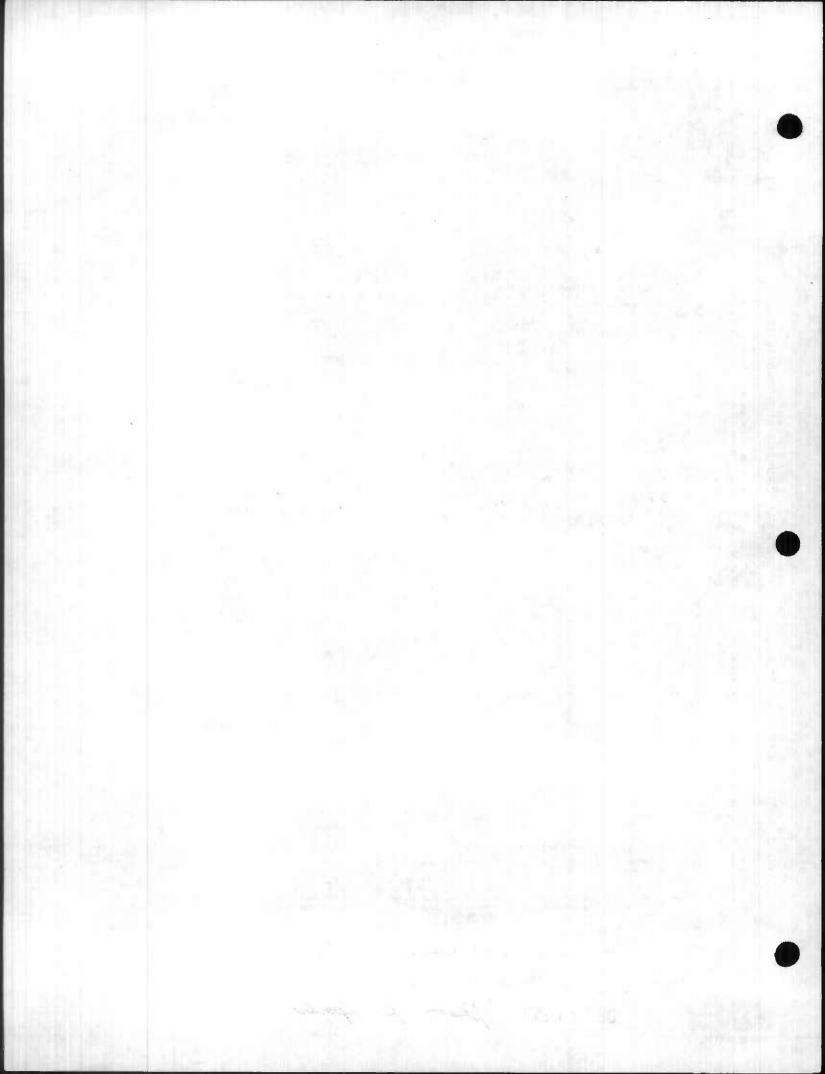
	Certifi  1. Decedent's Nama (First, Middle, Last)	cate of Death	Reg. No.	L 2900
Physician	Hilda S. Vaughn		Month Day Year	M . OD - M
/Medical Examiner	4a Facility Nama (If not institution, give street and number)	4b. City, Town, or L	ocation of Death 4c. County of D	eath
Examiner	Carroll Lutheran Village	Wester	ninster Carro	11
Funeral Director	220-16-3015 1 M 2 X F 86 Yrs. Mo	Under 1 Year If Under 24 Hrs.  Inths Days Hours Min.	8. Data of Birth Jan. 27, 1914	Birthplaca (Stata or Foreign Country) Maryland
28e-f show mouthed at rector	Usuat Rasidence of Decedent  10a. Stata 10b. County 10c. City, Town or Locatio  MD Carroll Wes	tminster		10d. Insida City Limits
Per M		Of. Zip Code	40c Chinn of Mhos	
th with	205 St. Mark Way	21158	10g. Citizan of What U.S.A.	Country?
5 2 3 5	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	Decedent of Hispanic Origin? (S <sub>I</sub> , specify Cuban, Maxican, Puartores 2 ☑ No Specify:	pecify Yes or No- Black, W Specify:	marican Indian, Thita, atc. White
Maryland 21215-0020 d 2 should be filled within 72 hours after th and Mental Hygiena. The marked other than "natural", or he traumatic avent, the Wed call Exemples To Be Completed by Ful	(Specify only highest grade completed) (Giva kind lita. DO N Elementary/Secondary (0-12) College (1-4or 5+)	S Usual Occupation of work dona during most of work IOT use retired)	16b. Kind of Busina Health	
Co Co	12 L.P		nearth	care
Maryland 2 12 should be filed v 12 should be filed v 14 marked other traumatic avent, th To Be Co	Unknown		e Shipley	
Marylan d 2 should be th and Mental 7 Is marked o traumatic ave	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Ad	1	ral Routa Number, City or Town, Stat	a. Zio Coda)
ond 2 a			esville, MD 21784	
6 - x 2 2 2	20a. Method of Disposition 20b. Place of Disposition cematary, cremator	(Nama of v or other place)	Data 20c. Location - City .2/27/00 Sykesvil	
Baltimor permit. Pages Department of Important: if it any injury or o	HAI		ME & CHAPEL, PA (1784 (410)-795-1400	
Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	a mode of dying, such as cardiac	or respiratory arrast,	Approximate Interval Batween Onset and Death
/Medical Examiner	Immediata Cause (Finat disease or condition resulting in death)  a. Acute Westerdi		en	ldy
68760, filose be associed a physician and as the buriel-transit edical Examinar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  Dua to (or as a consequence or Injury that initiated events  Dua to (or as a consequence or Injury that initiated events			
	resulting in death) Last			
D. El deat deat for selcie	Part It. Other significant conditions contributing to death but not resulting in the under	ying causa given in Part I.	23b. Did tobacco use contrib	uta to the cause of death?
ords, P.O. requires that the de- e-en signed by the a hould be deteched if	Maged Dementon		1 □ Yes 2 No 3 □	Probably 4 Unknown
D 2 2 0			24a. Was an autopsy performed?	lb. Wara autopsy findings available prior to complation of causa of death?
The late he pege			1□ Yas 2 No	1 Yas 2 No
Vital I elotan: The certificata lirector, per	25. Was casa refarred to medical axaminer?		th (Check only ona)	
다 사 등 T			oma 5 Rasidence 6 Othar (5	Specify)
After fune	27. Manner of Death    Statural   S   Pending   28a. Data of Injury   28b. Tima of Injur	28c. Injury at Work? 1 Yas 2 No	28d. Describe how injury occurred	
DIVISION AND AND AND AND AND AND AND AND AND AN	3 ☐ Suicide 6 ☐ Could not be detarmined 28a. Place of Injury - At homa, farm, street, f building, etc. (Specify)	actory, office	28f. Location (Street and Number of City or Town, Stata)	r Hural Houta Number,
Hosp 24 hou Fune Hely fil	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occur (Check only one)  Certifying Physician: To the best of my knowledge, death occur (Check only one)	urred at tha tima, data and place gation, in my opinion, death occu	and dua to tha cause(s) and manna red at tha tima, data and place, and	r as stated. dua to tha cause(s)
within Within To the comple	29b. Signature and titla of complete	29c. License number	29d. Data signed (M	
	(4/11-	D37949	Dec. 224	42000
	30. Name and address of person who completed contact death (fluin 3a) (Type, Print			
	Alexander Boadanluston 290	58 gener Ave	wexmiter	, MM, 21157
State Registrar	31. Data filed (Month, Day, Year)  DEC 2 6 2000  32. Registrar's Signature	South		9 18



State of Maryland / Department of Health and Mental Hygiene 1 2901

1 M. VO	rwerk		Ce	rtificate	of Death		Reg. No.	76701	
Physician	1. Decedent's Nama (First, Middle, L.			E / E Y		2. Date of Dea Month	ith Day	3. Time o	Death
/Medical	CAROLYN MARGAR		ζ			Decembe			A.M.
Examiner	4a Facility Name (If not institution, gi		1.0			Location of Death			
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Funeral Director		Sex 7. Age 1 M 2√2 F 9	(In yrs. last birthday Yrs.		ays Hours Min		, 1910	9. Birthplaca (State Country) NEW YORK	or i-oreig
8 m	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside C	ity Limit
23s or 28s-f show	PA SOMER	RSET	MEYERSI	DALE				1 X Yes	2 N
be notified Director	10e. Street and Number			10f. Zip Co	da		10g. Citizan of V	Vhat Country?	
23a c	1137 SHIRLEYS H	HOLLOW ROAD		155	52		U.S.A	Α.	
for man 23.	11. Marital Status	12. Was Decedant Ev Armed Forces?	ver in U,S. 13.	Was Decedent	of Hispanic Origin? ( Cuban, Maxicen, Pue	Specify Yes or No- rto Rican, atc.)	14. Race Blace	e - American Indian, k, White, etc.	
by By	1 Never Married 2 Married 3 Wildowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1□ Yes 2□			Specify		
t, the Madrell Completed	15. Decedent's E (Specify only highest gr	ducation rade completed)	16a. Dece	edent's Usual O	ccupation one during most of wo stired)	orking	16b. Kind of Bu	usiness/Industry	
d d	Elementary/Secondery (0-12)	College (1-4or 5+	)						
	17. Father's Nama (First, Middle, Las	4	NUI	RSE ANE	STHETIST	me (First, Middle,	MEDIO		-
B & G	PETER MacINTOSH	•				HAYES	Maiden Sumam	16)	
To To			405 44-9	A dd (O			City of Town	State Tie Code	
T is m	19a. Informant's Name/Relationship ELSA L. VORWERF				reet end Number or F			LAND, MD 21	502
the the	20a. Mathod of Disposition	(/ DAOGITEM	20b. Placa of Disp			Deta		City or Town, Stata	302
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Injury P	4 Donetion 5 Other (Special Signature of Funaral Service Lice	**	CUMBERL		ddress of Facility	12/20/2000	COIVII	BERLAND, M	
Important: I any Injury o once.	21. Signature of Punaral Service Lice	U ,			H FUNERAL	HOME. P	Δ.		
	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	bocheves		202 GRE	ENE ST.	UMBERLAN	D, MD	21502 Approxima	
ysician ledical aminer	Immediate Cause (Final disease or condition resulting in death)	a Left Ace		racture	with Comp			Onset and	Doaur
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	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0		at make light	NI	- May			
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# O =	Congestive Hear	t Failure					2010	OE Frommy 42	JOHRHO
old be							an autopsy	24b. Were autopsy available prior	findings
sate has been single page 2 should I	Coronary Artery	Disease				Appro	med? val	completion of of death?	
page 2							es 2 No	1 ☐ Yes 2[	7 No
	25. Was case referred to medical				26 Place of D	eath (Check only o		12700 22	3.10
	exeminer? 1⊠ Yes 2□ No	Hospital:	2 ER/Outpatie	ent 3 DOA	Other:	Home 5 ☐ Resid		er (Snecity)	
# - F	27. Manner of Death	28a. Dete of Injury (Month, Day			Injury at Work?	-	now injury occur		
To the Funeral Director: After it completely filled in by the lunere completely filled in by the lunere Medical Certification:	1 □ Natural 5 □ Pending 2 ☑ Accident investigation			рм	Work? 1 ☐ Yes 2 ☑ No	Subject	fell in	n her room	
al Director: After t led in by the luners Certification:	3 ☐ Suicida 6 ☐ Could not	a   289. Pieca oi injur	y - At home, farm, s	treet, factory, of	fice	28f. Location (	Street and Numb	per or Rurel Routa Nu	mber.
d in	4 Homicide	building, etc.	(Specify) Living F	acility		Hol.low	Road Me	m 107, 1137 Eyersdale, Pr	Shir.
pletely fille edical C		hysician: To the best of miner: On the basis of e	my knowledge, dea	th occurred at the		e, and due to the	cause(s) end ma	anner es stated.	
Me Me	29b. Signatura and titla of certifiar			29c. Li	censa number		29d. Date signe	d (Month, Day, Year)	
- 0	- Thu		1	- 1	2012	4	Decembe:	r 21, 2000	)
/	2011	2 1 100		-	7 7107				
	30. Name and address of person who	14.			oot Balti	more Me	ariland .	21201	
	21 Data filed affects Day Yours	1 110 000	THE STREET	elle Str	eet, Balti	more, Ma	TATQUO .	21201	
State	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	4 10	no Kal				

DEC 2 7 2000



State of Maryland / Department of Health and Mental Hygiene,

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2000 Month **Physician** Fernando Bryan Villegas 28, Dec. 2:40 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 219-80-9561 Yrs. Director Aug 9, 1971 DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2000 Directo Maryland Montgomery Olney 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code 8 18158 Headwaters Dr. 20832 238 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. 1 No Specify Ecuadoran/ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 à 3 ☐ Widowed 4 ☐ Divorced Puerto Rican White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Giant Pharmacy Assistant Manager 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) should be nd Mental: merked or Thomas Villegas Georgina Laboy I. Pages 1 and 2 should ritment of Health and Mari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Thomas E. Villegas/Father 9104 Drake Place, College Park, MD 20740 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery 01/02/01 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home, INC. dames 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Que to (or as a consequence of) Physician/Medicai Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Seizure À 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medicel 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28d, Describe how injury occurred 27. Manner of Death 28b. Time of Sion 1 Naturai 5 Pending Injury Car accident Dec, 24, 2000 1047 a.M 1 Yes 2 No death. investigation 2 Accident 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

YOAA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end manner stated.

28f. Location (Street end Number or Rural Royte Number, City of Town, State)

Wheat of the provided Rd, Wheat of the ceuse(s) end menner as stated.

28f. Location (Street end Number or Rural Royte Number, City of Town, State)

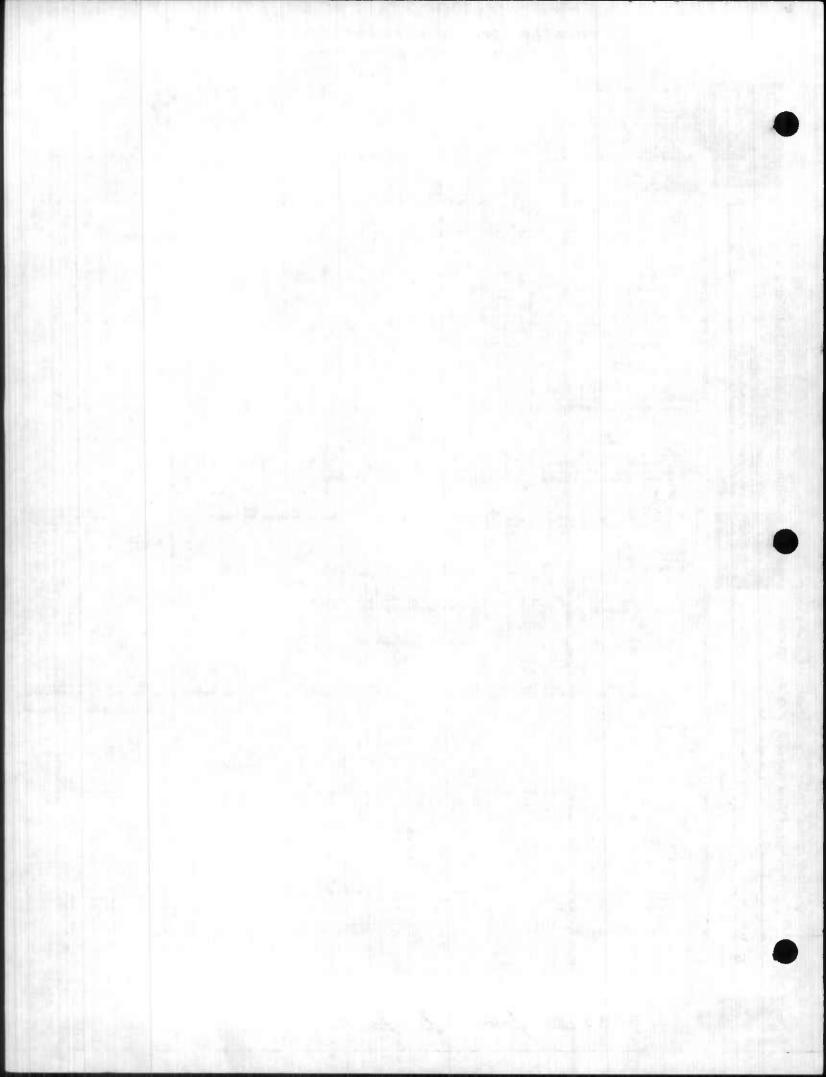
And All Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. Director: 3 Suicide 4 Homicide within 24 hours a To the Funeral C completely filled 29a Certifier To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Hatricia X 10 Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Pike, PMB 348, Rockville, MD 20852 ille KOCKV amicia 61 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Amend #1,12/27/200, BMW, Montg. Co. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Theo vanHemert Month Year **Physician** DMON DECEMBER 25 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTOONOR 4232 CHANGET FOREST STORES OUNE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign **Funeral** Hours Days Months 1 M 2 F NETHERLANDS 81 Yrs Director 216 06 0945 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10d. Insida City Limits 10b County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No OLNEY MD. **MONTGOMERY** Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? with 4232 CHARLEY FOREST STREET **NETHERLANDS** 20832 Funeral deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, efc. 12. Wes Decadent Ever in U,S. Armed Forces? 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: WHITE à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) NETHERLANDS Hygiena. Elamantary/Secondary (0-12) College (1-4or 5+) **EMBASSY** COMMUNICATIONS ATTACHE other 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Heelth and Mental H Be vanGelder Cornelia Willem vanHemert 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4232 CHARLEY FOREST ST., OLNEY, MD. Wilhelmina J. vanHemert, Wife other 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ħ 4 ☐ Donation 5 ☐ Ofher (Specify) METROPOLITAN CREMATORY 12/27/00 ALEXANDRIA, VA. 21. Signature of Funeral Service Licensea 22. Name and Address of Facility
MURIEL H. BARBER FUNERAL HOME 120 wii P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** /Medical Immediata Causa (Final HOUTENOSC EPOTIC CHOID LATCUAR DISTAR disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner certificate be axecuted physician and s the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) 88 use 0 23b. Did tobacco use contribute to the cause of death? detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown signed by 1 ρ 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy Completed paga 2 1 ☐ Yes 2 No 1 Yes 2 No cartificate Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner r 1 Xes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 this funeral 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 DeNatural Injury 5 Pending aftar death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital or J
 A hours after
 Funeral Directory filled in b 29a. Certify 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua fo tha causa(s) and manner as stated. Medical To the Hosp within 24 hor To the Fune complately fi 25 Medical Examiner: On the basis of examination and/or Investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signa 29c. License number OME DECOMBOR 25, 200) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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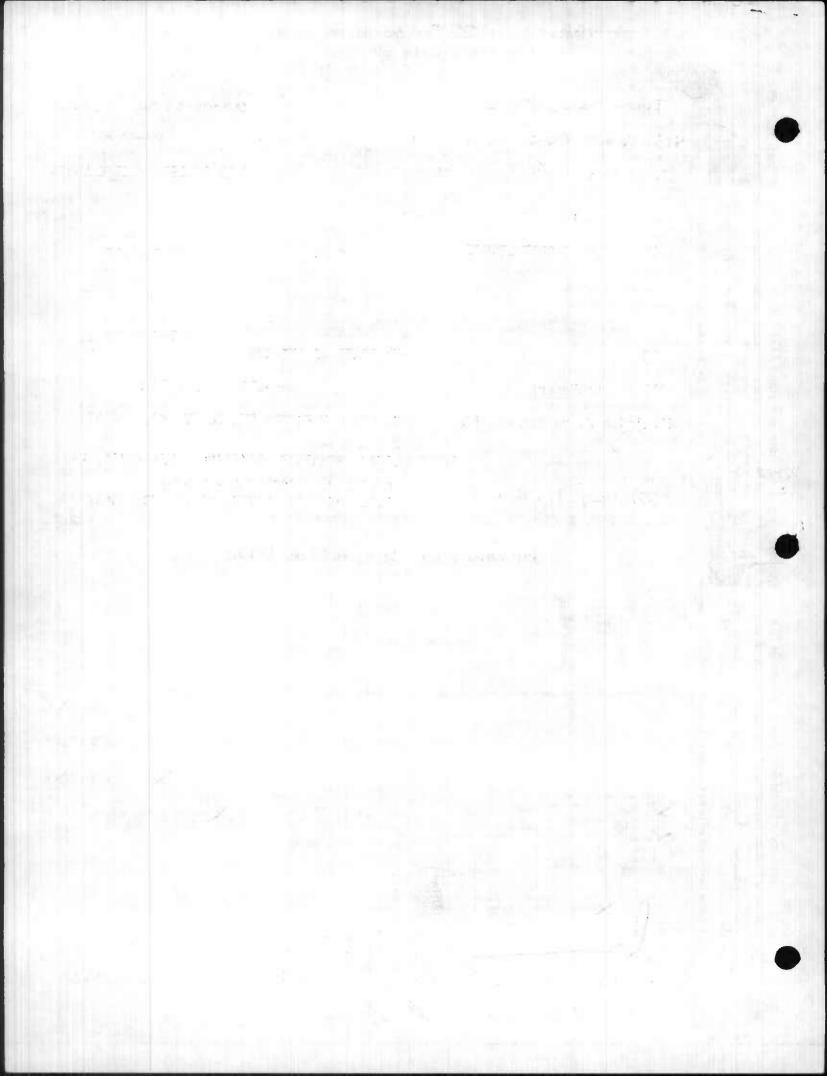
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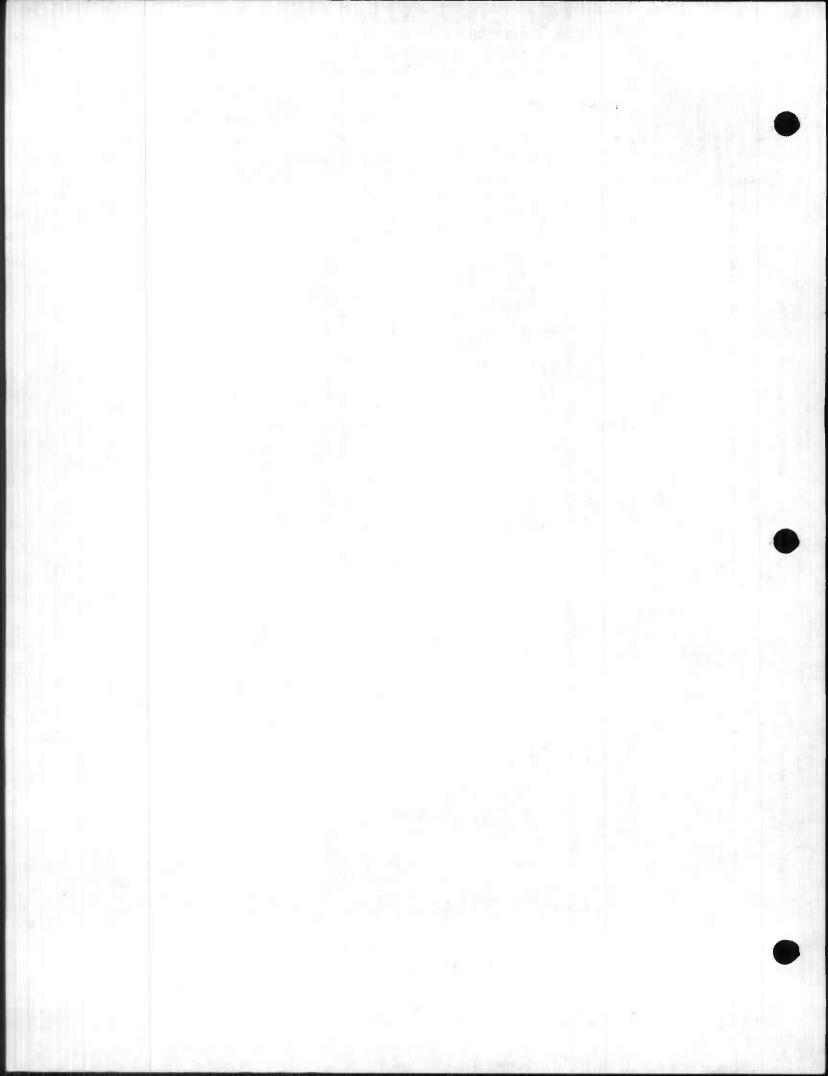
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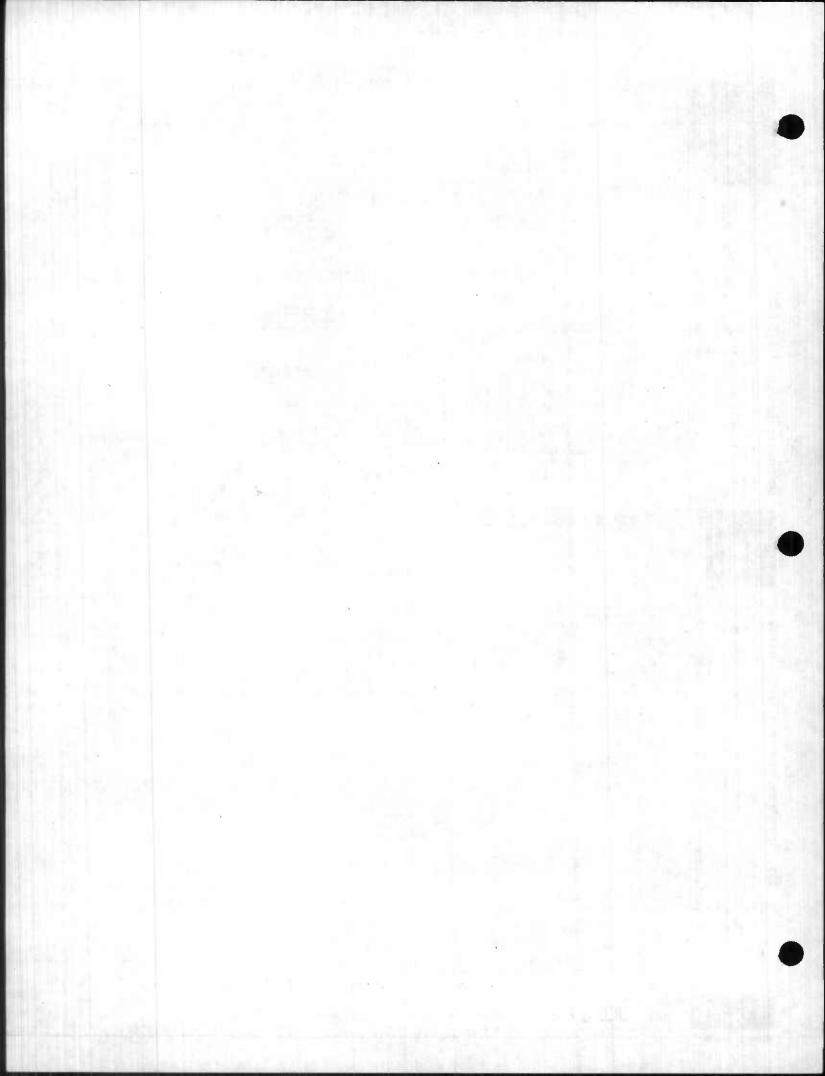
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9	-	Street and Number	onegome	Ly		Garc	ILETS	10f. Zip Co	de			10g. Citizan	of What Cou	intry?
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by Funeral Director	1[	arital Status  Never Marriad  Widowed 4		12. Was Dec Armed Fo 1 Yes If Yes, Gi	orces? 2⊠No ive	in U,S.	If Y	as Decedent (as, specify Yes 213	Cuba	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		Race - Ameri Black, Whita ecity: Wh	
ba d	- 3		Decedent's Edu	Year or D	Jaies.	168.	Decedar	nt's Usual O	ccupa	ation		16b. Kind	of Business/Ir	
Completed	Ela		nly highest grad			S	(Give kir life. DC ecre	NOT use n	tona d etired	during most of wor	king	Wisco		
Be Co	17. F	ather's Name (First	, Middle, Last)							18. Mothar's Nar	ne (First, Middla			
To B	He	enry Haub	rich							Martha	Blechsc	hmidt		
-	19a.	Informant's Name/	Relationship (T)	rpe, Print)	11.15	196	. Mailing	Addrass (S	treet s	and Number or Ru	ral Route Numb	er, City or To	own, Stata, Zi	ip Code)
	Del	ora J. Fr	ohna/Da	ughter						ill Road				and 20850
		Method of Dispositi  ☑ Burial 2 ☐ Cre		Removal from		b. Place of cemete.	Disposit ry, crema	tion (Name of tory or other	of ir plac	(e)	Dec. 29,	20c. Locat	ion - City or T	own, State
	4	□ Donation 5 □	Other (Specify)		P	rairi		me Ce	-		2000			isconsin
SUCE	21. S	ignatura of Funara	Service Licens	<del>00</del>	MO	0198	Rob 300	West	Mo	umphrey ntgomery	Funeral Avenue	Home/	Rockvi	lle, Inc.
Examiner	disaa	ediata Cause (Finalisa or condition ting in daath)  ientially tist conditlor, leading to immede. Enter Underlying (Cisease or injur)		Met		ic Ov	consaqua	ance of):	cin	oma				2 years
Physician/Medical E	that I	e. Enter Underlying e (Disease or injur nitiated evants ting in death) Last	1	d	Dua t	o (or as a	consaque	ence of):						
Sicia	Part II	I. Other significant	conditions co	ntributing to d	leath but not	resulting i	n tha und	lerlying caus	se giv	en in Part I.	23b. Dld	tobacco us	e contribute	to the cause of deat
y Phy											10	Yes 2K	No 3□Pr	obably 4 Unknow
Completed by	_										24a. Was	s an autopsy omed?	a	Vere autopsy findings valiable prior to completion of cause of death?
Con											10	Yes 2K	No 1	☐ Yes 2☐ No
Be	01	/as casa raferred to xaminer?		Hospital:					Oth	A.F.	ath (Chack only			
7	-	Yes 21 No		10			tpatient Time of	3□ DOA 28c.		4-EN Nursing i	lome 5 ☐ Ras			cify)
Certification:	1 2	⊠Natural 5   ☐ Accident	Pending investigation		of Injury oth, Day Yea		njury	М		k? Yas 2□No				ral Route Number,
ertif		Homicida	datarmined	288. Place build	e of Injury - a ling, atc. (Sp	necify)	irin, Straa	it, lactory, o	ntiC8		City or To	own, State)	VAINUE OF FIU	I I VISO I VIII (UOI)
				ner: On the b						na, data and place pinion, daath occu				
							HI Y	29c. L	icens	e number		29d. Date s	igned (Month	Dav. Year)
Medicai C	206.	Signature and title	of certifier	)										
edicai		Signature and title	5 G. H	STORELL Omplated cau	se of death	(Item 23a)	(Type. Pr		072	285			per 23	



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 4 2 9 0 5

				Certifica	ate of	Death		Reg. No.		
	1. Decedent's Nama (First, Middla, Las	1)					2. Date of Dea	ath Day	Year	3. Time of Death
Physician /Medical	Han Kap Woo						Decembe			4:30 AM
Examiner	4e Facility Nema (If not institution, give	street end number)				4b. City, Town, or	Location of Deeth	4c. County	of Death	
	13803 Congress D	rive				Rockvill		Montgo	omery	
Funeral Director	212-21-8462	9x ☑ M 2□ F	(In yrs. last birth	Month	der 1 Yeer Days		(Month, Day	h, Yeer) 15, 1915		lace (Stata or Foreign try) rea
pu .	Usual Residance of Decedent  10a. State 10b. County		10c. City, Town	or Location					11	Od. Inside City Limits
aho sho										1 ☐ Yas 2 XNo
vith the Ma to 28a-fa be noutled	Maryland Montgome	ery	Rockvi		Zip Coda			10g. Citizan of W	Part Count	
ath with the Marylan 23a or 28e-f show ust be notified at	10000 0	ive			0853			Korea	mat Coun	ny r
urs after de Mr. or Nems Languer n by Fune	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forcas? 1 ☐ Yas 2 ☒ N If Yas, Giva Yaar or Dates:			cedent of I pecify Cub	Hispanic Origin? (Spen, Maxican, Puar Specify:	Specify Yas or No- to Rica <i>n</i> , atc.)	Specify:	- Amarica k, White, a	atc.
od within 72 hours ygiane. or than "natural", if, tre traded by	15. Decedant's Ed	ucation	16e. l	Decedent's U	sual Occu	pation	whine	16b. Kind of Bu	sinass/Ind	fustry
	(Specify only highast grade Elementary/Secondary (0-12)	College (1-4or 5-	+)	lifa. DO NOT	use retire	during most of wo	rking			
d withing giane.	12	4		acher				Educati	ion	
	17. Fether's Name (First, Middle, Last)					18. Mothar's Na	ma (First, Middla,	Maiden Surnam	a)	
Mental Me	Seung Jun Woo					Kan Na	Woo			
A DE E	19a. Informant's Name/Ralationship (7	ype, Print)	19b.	Mailing Addre	ess (Stree	f and Number or R	ural Routa Numbe	er, City or Town,	Stata, Zip	Coda)
	Duk Ho Woo - Son		13	803 Co:	ngres	s Drive,	Rockvil	le, MD 2	20853	
nemit. Pages 1 a Separtment of His reportant: if them my injury or other most.	20s. Method of Disposition	2 - 2 - West	20b. Place of	Disposition (A	Vame of		Date	20c. Location -		
Pages mit: if in iny or o	1 □Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		Norbec		77		12-27-00	Olney,	Mar	vland
Physician /Medical Examiner	23a. Partt. Enter the disease, or comp shook, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	Metast	atic co	lon ca	ncer	to liver	c or respiratory ar	rest,	1	Approximate Interval Between Onset and Death
5	TO THE PART OF THE		Oue to (or as a o	onsequence o	M):				-	
min min		b	Cancer		- Pa					
be executed ician and butsi-transit	Sequentially list conditions, if any, leading to immediate cause. Entire Underlying Cause (Disease or Injury that initiated events	c.	Oue to (or as a co							25,200
certificate be en riding physician use as the buris rv/Medical E	resulting in death) Last	d	Que to (or as a co	onsequence o	0:					
the state of the							- LITTLE COLOR		1	
the day the sched	Part II. Other significant conditions co	intributing to death bu	t not resulting in	the underlyin	g cause g	wen in Part I.				the cause of death'
£ X D	Tumor cachexia, d	ehydration	1				10	Yes 2X0 No	3 □ Prot	bebly 4 Unknow
been sign should be								an autopsy med?	000	are autopsy findings allable prior to impletion of cause death?
The lass page 2							101	res 250 No	10	Yes 250 No
certificate rector, pa	25. Was case referred to medical					26. Place of De	with (Check only o	me)	2 3 6 9	
	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Timpatier	nt 2DER/Out	nation: 3	DOA O	har	Home 5 1 Resid		er /Specifi	0
	27. Manner of Death 1 ⊠Natural 5 □ Pending	28s. Date of Injury (Month, Day	y 28b. To		28c. Inju		B1071	now injury occurr		
phal or Attending Pours after death.  and Director. After Illind in by the funers is Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home, far (Specify)				28f. Location (5 City or Tox	Street and Numb en, State)	er or Rura	I Route Number,
Hospi 14 hou Furner 18ty III	29a. Certifier 1	nician: To the best of iner: On the basis of and manner stat	examination and	death occurr for investigati	ed at the t on, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, s	oner as st and due to	tated. the cause(s)
To the To the comple	29b. Signature and title of certifier	- 11	-	13	29c. Licen	se number		29d. Date signed	d (Month,	Day, Year)
	De 1-1	1 Km	***		73.64	0079		Dogomb	or 26	5 2000
16	Trunel	que	100	Para Maria	1)4)	0078		Decemb	er ze	5, 2000
	30. Name and address of person who o			-	#2	10 Deal-	1110 M	han I rem	2085	5.2
	Daniel Kim, M.D.	121 Congr		1 Lane	, #3	to, KOCKY	/iie, Ma	ryrand	2003	) 4
State	31. Dete filed (Month, Day, Year)  NFC 2 7 20		r's Signatura	1	make					



	RED WHITE MENDED# 23,	; ,27 perME G793 031901 S		ryland / Depa <i>Cei</i>	artment of hartificate of			iene	1.2	906
	Physician	1. Decedent's Neme (First, Middle, Le	est)	WHITE			2. Dete of Dea Month	Dey	Year 2000	3. Time of Death  14:23
	/Medical Examiner	4e Facility Neme (If not Institution, gir	ve street and number)			4b. City, Town, or L	1	4c. County	ot Death	
1	Funeral			(In yrs. last birthdey)	If Under 1 Yeer Months Deys	Lanham If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Day	Year)	9. Birthple Country	orge's
ı.	Director	Usuat Residence of Decedent		75 Yrs.			JULY 8	, 1925	MASSA	CHUSETTS
0	nyland show	10s. Stete 10b. County		10c. City, Town or Lo	cation				100	d. Inside City Limits
	with the Merylan  a or 28a-f show  be notified at	MD. MONTGO	MERY		TAKOMA I	PARK		0- 00	10-1-0-1-1-1	1 X Yes 2 No
	E 9 8	10e. Street and Number 7051 CARROLI	AVE		10f. Zip Code	912		0g. Citizen of V		yr
	r items 234	11. Meritel Stetus	12. Wes Decedent E	ver in U,S. 13.		Hispenic Origin? (Sp an, Mexicen, Puerto	ecify Yes or No-	14. Rec	e - America	
Maryland 21215-0036	al', or he	3 ☐ Widowed 4 🖾 Divorced	Armed Forces?  1 Yes 2 AN If Yes, Give Yeer or Detes:	0	1 ☐ Yes 2 ② No		Hican, etc.)	Specify	k, White, et	
5-0	n 72 hours natural', of a	15. Decedent's E (Specify only highest gr	ducetion ade completed)	16a. Dece	dent's Usuel Occup	pation during most of work	ring	16b. Kind of Bu	isiness/Indu	istry
121	led within 72 ho hyglene. her than "natura nt, the Medical Completed	Elementery/Secondery (0-12)	College (1-4or 5-	life.	SALES CI			D	ETAIL	
d 2	Date:	17. Father's Neme (First, Middle, Last	)		DATES CI	18. Mother's Nem	e (First, Middle,			
lan		GEORGE	PUINAM				JULIA	OLI	VER	
ary	permit. Pages 1 end 2 should be Department of Health end Menie Important: if item 27 is marked and july or other traumatic events of the County or other Traumatic and the County or other traumatic and the County or other traumatic and the County of the County of the County of Health and County or Healt	19e. Informent's Neme/Reletionship		19b. Maili	ng Address (Street	end Number or Rui		, City or Town,	Stete, Zip C	Code)
	end 2 ealth n 27 I	BRUCE WHITE	/son	652		AVE., UNI				
Baltimore,	Pages 1 nent of H int: if iter iry or oth	20e. Method of Disposition  1  Buriel 2  Cremetion 3	Removel from State	20b. Plece of Dispo cametery, crea	sition (Neme of metory or other ple		Dete	20c. Location -		
Him o	it. Partmen	4 Donetion 5 Other (Speci	(y)		ERS CREMA		12/23/00	RIVE	RDALE	, MD.
Ba	pemit. Departu Importu any Inju	21. Signature of Funeral Service Lieu	11.0		2. Name end Addre			l CLEVE		
		23a. Pert1. Enter the disease, or con	A PERMIT			FUNERAL HO				E, MD.2073' Approximete
	Physician /Medical Examiner	Immediate Cause (Finet disease or condition resulting in death)	4.	AR DISEASE W		CATIONS			1	Onset and Death
8760,	ate be executed hysicien and the burial-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	b	Due to (or es e consec	quence of):	3.6				
Box 687	ata the the the	resulting in deeth) Last	d	Due to (or es a consec	puence of):					
	death e atte	Pert II. Other significant conditions	contributing to death but	t not resulting In the u	nderlying cause gi	ven in Part I.	23b. Did to	obacco use co	ntribute to	the cause of death?
9, P.O	v requires that the death certific been signed by the attending p should be detached for use as letted by Physician/Me.		CEEE III				101	′es 2□ No	3 Probe	ably 4 Unknown
Division of Vital Records,	been s should						24a. Wes e perfor		evai	re eutopsy tindings ilable prior to appletion of cause leath?
R	The lew ste has page 2						10(Y	es 2 No	1)(	Yes 2□ No
/ita	certificate rector, pag	25. Wes case referred to medical examiner?				26. Plece of Dee	th (Check only or	ne)		
5	Physician; this certific rel director, To Be	Yes 2 No	Hospitel:		II 3LI DOA		ome 5 Resid			)
no	After funer	27. Menner of Deeth  1 X Netural 5 Pending Investigation	28a. Dete of Injun (Month, Dey	Year) 28b. Time o	Wo	iry at ork? ]Yes 2 □ No	28d. Describa h	ow injury occur	red	
Division	or Attending after death.  Director: After in by the funder of the funde	2 Accident Investigetic 3 Suicide 6 Could not t 4 Homicide determined	OB Disas of Injur	ry - At home, farm, st (Specify)			28f. Location (S City or Tow	treet end Numb n, Stete)	per or Rural	Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier 1 Certifying Pl	hysicien: To the bast of miner: On the basts of and manner stell	examinetion end/or in						
	Within To the comple	29b. Signeture end title ot certitier	111		29c. Licen	se number		29d. Dete signe	d (Month, D	Jey, Year)
		1 - Theal	. Il K	tra	_	oane		Decembe	r 23	2000
		30. Name and address of person who	completed cause of de	ath (line 23a) (Type,	Print)	June		Decembe	1 231	2000
			liking			treet, Ba	ltimore,	Maryla	and 21	201
	State Registrar	31. Dete filed (Month, Dey, Year) DEC 2 6 2	000 Page	r's Signeture $\mathcal{G}$ .	spork.	v				

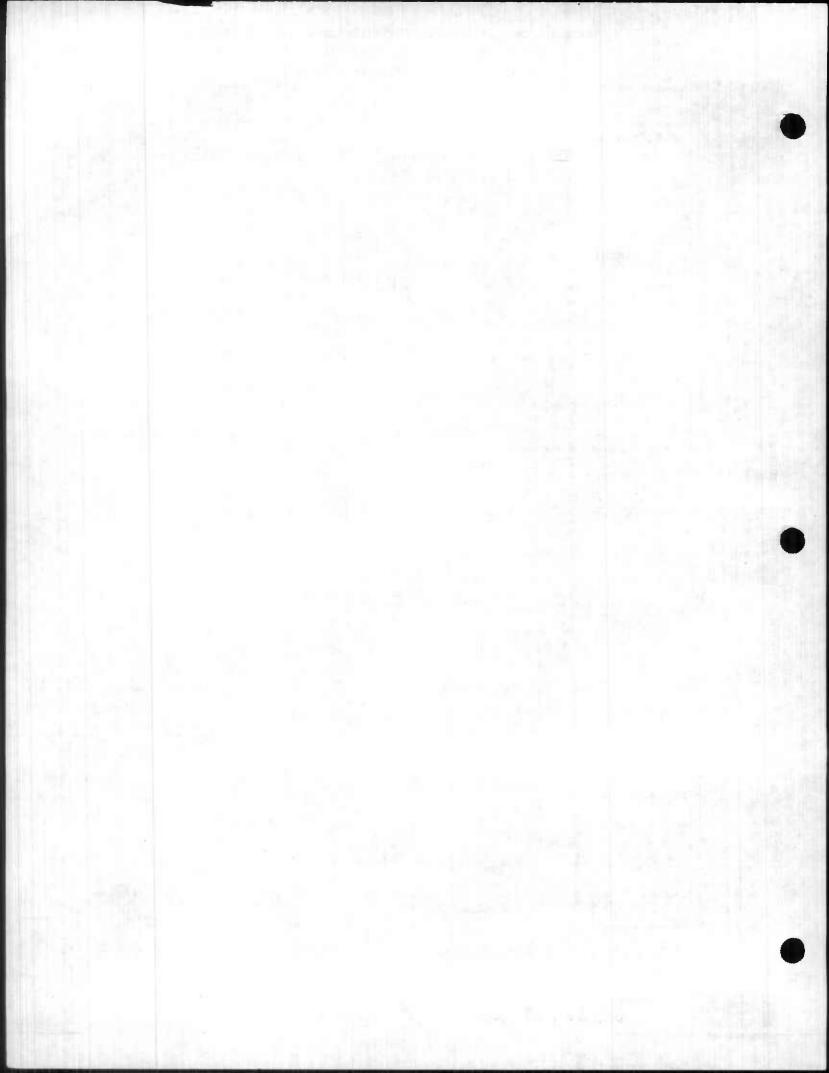
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State of Maryland / Department of Health and Mental Hygiene

			Otato or i	mar y ran		Certifica		Death	· · · · · · · · · · · · · · · · · · ·	Reg. No.	42	907	
Physician	1. Decedent's Name	e (First, Middle, Las	1)						2. Date of D Month	eath Day	Year	3. Time of I	Death
/Medical		hite Sr.							Decemb		-	8:15ar	n
Examiner	4a Facility Name (II			er)				4b. City, Town, or	Location of Dea				
	16121 Oak							Silver Sp		Montg			
Funeral Director	5. Social Security No. 272-14-06 Usual Residence of	84 H	9X 7. □ M 2□ F	Age (In yrs.	last birtho	Months	or 1 Year Days	Hours Min	(Month, D		9. Birthpi Coun DH	lace (State or try)	Foreign
1 L-	10a. State	10b. County		10c. Ci	ty, Town o	or Location					10	Od. Inside City	y Limits
vin the Maryla or 28e4 shor be notified at Director	MD	Montgome	ry	Sil	ver	Spring						1 🗆 Yes	2⊡ No
	10e. Street and Nun 16121 Oak					10f. Z	ip Code			10g. Citizen of United			
her death in them 23 siner must	11. Marital Status	militi na.	12. Was Decede	nt Ever in U	,s.			lispanic Origin? (S an, Mexican, Puer	Specify Yes or N		e - Americ		
ura after of the campine tramper by Fur		ed 🐫 Married	Armed Force 本口 Yes 21 If Yes, Give Year or Date	□No				Specify:	to Rican, etc.)	Specify Bla	ck, White, o	etc.	
P P P P P P P P P P P P P P P P P P P		15. Decedent's Ed	ucation	11 10	16a. D	ecedent's Us	ual Occup	pation		16b. Kind of B		Justry	
Maryland 21215-0036 d2 should be fised within 72 hours at this and Mental Hygiens. T is marked other than "natural", or traumetic event, the Medical Exam. To Be Completed by F	Elementary/Secon 12	ify only highest grad ndary (0-12)	de com <i>pleted)</i> College (1-4	or 5+)		Give kind of w ife. DO NOT AC Mec]		oation during most of wo d)	prking	U.S. Po	stal	Servi	e
d Hand	17. Father's Name (	(First, Middle, Last)		-				18. Mother's Na	me (First, Middl	e, Maiden Surnen	ne)		
land land be n ked out	William	White						Nanny V	Valker				
The state of the s	19a. Informant's Na	me/Relationship (7	ivpe. Print)		19b. N	Aailing Addre	ss (Street	and Number or R	lurel Route Num	ber, City or Town	State, Zip	Code)	
Mag day	Hannah Wh					District Country		Rd., Si					
re, N	20a. Method of Disp			20b. I	_	isposition (No crematory or			Date	20c. Location			
Page Page ment if uny or	4 Donation	Cremation 3 🔀 5 Other (Specify	)	100		Grove	Ceme	tery	Dec 30 2000	Cincinn	ati,	ОН	
Ball Depart Import any inj ance	21. Signatura of Fu	Rena L.	1/e li	tt		Rapp 933 G	Fune	ss of Facility ral & Cr Ave. Si	emation lver Sp	Service	S		
Physician /Medical Examiner	23a. Part 1. Enter the shock, or hear shock, or hear shock and shock are shock as a shoc	ne disease, or comp it failure. List only d Final n	lications that causine ceuse on each	mer's	Dise	ase		ng, such as cardia	c or respiratory	arrest,	1	Approximate Interval Betwoonset and D Severa years	eath
5				Due to (	or as a co	nsequence of	·):						
68760, ifficate be executed physician and as the burial-transit edical Examiner	Sequentially list cor if any, leeding to im cause. Enter Unde Ceuse (Disease or	nditions, imediate rlying Injury	b. ————————————————————————————————————	Due to (	or as a co	nsequence of	):						
E 0 # _	that initiated events resulting in deeth) L		d	Due to (d	or as a con	nsequenca of	):				1		
deet deet deet de atre	Part II. Other significant	cant conditions co	ntributing to deat	h but not res	ulting in t	he underlying	cause gir	ven in Part I.	23b. Di	d tobacco use co	ntribute to	the cause o	f death?
dS, P.O. Box ires that the death cert signed by the attending d be detached for use.	Diabetes	s mellitu	s, dysph	agia					10	Yee 2□ No	3 ☐ Prol	bably ¥□ (	Jnknown
ew requests been 2 should									24a, Wa	s an autopsy formed?	av	ere autopsy fi ailable prior to mpletion of co death?	0
The I	321 6								10	Yes ZENo	10	Yes Ž	No
Vital Ricent The k certificate he irector, page	25. Was case refer	red to medical	2000					26. Place of De	eath (Check only	one)			
Physici Physici rithis cer rithis cer rithis cer rithis cer	examiner?	No	Hospitel: 1   Inp	atient 2	ER/Outp	atient 3 0	Oti AOC	ner: 4 Nursing	Home 5□Re	sidence 6 Otl	ner (Specif	y)	
lon of nding Physith.: After this e funerel di	27. Menner of Death ty Neturel 2 Accident	5 Pending Investigation	28a. Date of I (Month,	njury Day Year)	28b. Tin Inje		28c. Inju Wo 1	ny at rk? IYes 2 □ No	28d. Describe	how injury occu	rred		
Division of To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Pleca of building,	Injury - At h etc. (Special	ome, farm	n, street, facto	ory, office		28f. Location City or T	(Street and Num own, Stete)	ber or Rurs	I Route Numi	ber,
n 24 hound n 24 hour ne Funera pletely fill edical	29e. Certifier (Check only one)	1☐ Certifying Phy 2☐ Medicat Exam	rsician: To the be iner: On the basis and manner	s of examina	wledge, o	death occurre or Investigation	d at the ti	me, date and place opinion, death occ	a, and due to the curred at the time	e cause(s) and m e, dete and placa,	enner as si and due to	tated. the cause(s)	)
To the somp	29b. Signature and	title of certifier				2	9c. Licens	se number		29d. Date signe	ed (Month,	Dey, Year)	
5+1	<b>&gt;</b> X	21.	+	7.6	- 4	D4	14582			12-	76-	-00	
	30. Name and addre		ompleted cause of							, , ,			
	Sona Bha	tnagar M.	D. 602 C	Center	st.		e 209	, Mt. A:	iry, MD	21771			
State Registrar	31. Date filed (Mont	FC 2 9 20		Istrar's Signa	ature	1. 1	park	1					

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First Middle Last) 2. Data of Death 3. Time of Death Day **Physician** John Aubrey Wheeler, Jr. 27, 2000 4c. County of Death 4:59 pm 4b. City, Town, or Location of Death /Medical 4a Facility Nama (If not institution, giva street and number) Examiner Washington Adventist Hospital

5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Takoma Park Montgmery Birthplaca (State or Foreign Country) **Funeral** 1X M 2□ F Months Days Hours Min Yrs. 83 Director 577-38-6643 Aug 8, 1917 South Carolina Usual Rasidence of Decedent Pages 1 end 2 should be filed within 72 hours after deeth with the Menyland nent of Health end Mental Hygiene. 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yas XXNo Directo Maryland Montgomery Wheaton 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number 8 Herna 23a Funeral 2607 Elnora Street 20902 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1∑ Yas 2 □ No If Yes, Giva Yaar or Detes:1942-1946 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 6 1 ☐ Yas 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Public Information Officer US Government 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) h end Mental I Lucia Talley Oakman John A. Wheeler 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. informant's Name/Ralationship (Type, Print) permit. Pages 1 end 2 Department of Health e Important: If Item 27 Is 2607 Flnora Street, Wheaton, MD 20902

20b. Place of Disposition (Nama of camatery, cramatory or other place)

Data

20c. Location - City Dorothy L. Wheeler / Wife Baltimore, other 20a. Mathod of Disposition 20c. Location - City or Town, Stata 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata

Metropolitan Crematory

Physician /Medical

and

detached signed by the

8

pege 2 should Completed

· has r

spital or Attanding Physicien: Theoris after death.

neral Director: After this certificate filled in by the funeral director, pe

To the Hospital e within 24 hours a To the Funeral D

completely

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Certification: To

Box 68760

P.0.

Division of Vital Records,

any Injury

immediate Cause (Finel disaesa or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be asscuted

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events that initiated events rasulting in death) Last

4 □ Donation 5 □ Othar (Specify)

21. Signature of Funaral Service Licenses

22. Nama and Addrass of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901
anter the mode of dying, such as cardiac or respiratory arrest,
Intervel Between
Onset and Death 23e. Perit: Enter the disease, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. SCHEMIC ARDIOMYOPATHY HEROPOLEROND Dua to (or as a consequence of):

Part II. Other significant conditions contributing to death but not rasulting in the undarlying causa givan in Part I. VACVE

23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes en eutopsy performed?

24b. Were autopsy findings available prior to complation of causa ot death?

1 Yas 2 No

12/29/00 Alexandria, VA

1 ☐ Yas 2 ☐ No

30

25. Was casa referre	ed to medical				26. Pleca of D	eath (Check only ona)
axaminer? 1 ☐ Yas 2 ☐	\\\	Hospital: 1 ☐ Inpatiant 2	ER/Outpatient	3□	OOA Other: 4 Nursing	Homa 5 ☐ Rasidance 6 ☐ Othar (Specify)
27. Mannar of Death (Natural 2 Accident		28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	М	28c. Injury at Work? 1 Yas 2 No	28d. Dascribe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be detarmined	28a. Plece of Injury - Al I building, atc. (Spec	homa, farm, stree	it, fact	ory, office	28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

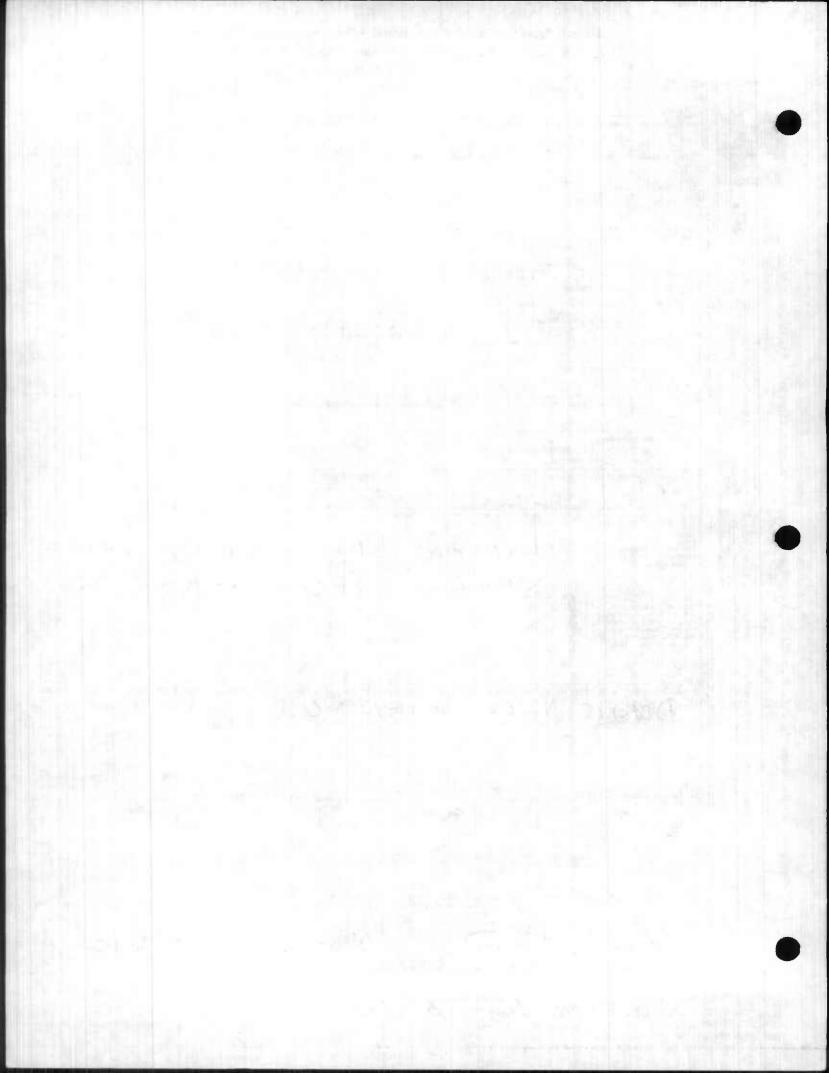
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred et the time, date and piece, end due to the ceuse(s) and mannar stated. 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier

30. Nama and addrass of person who completed cause of death (Herri 23a) (Typa, Print)

Samue1 Itscoitz, MD 10313 Georgia Ave., #306, Silver Spring, MD 20902

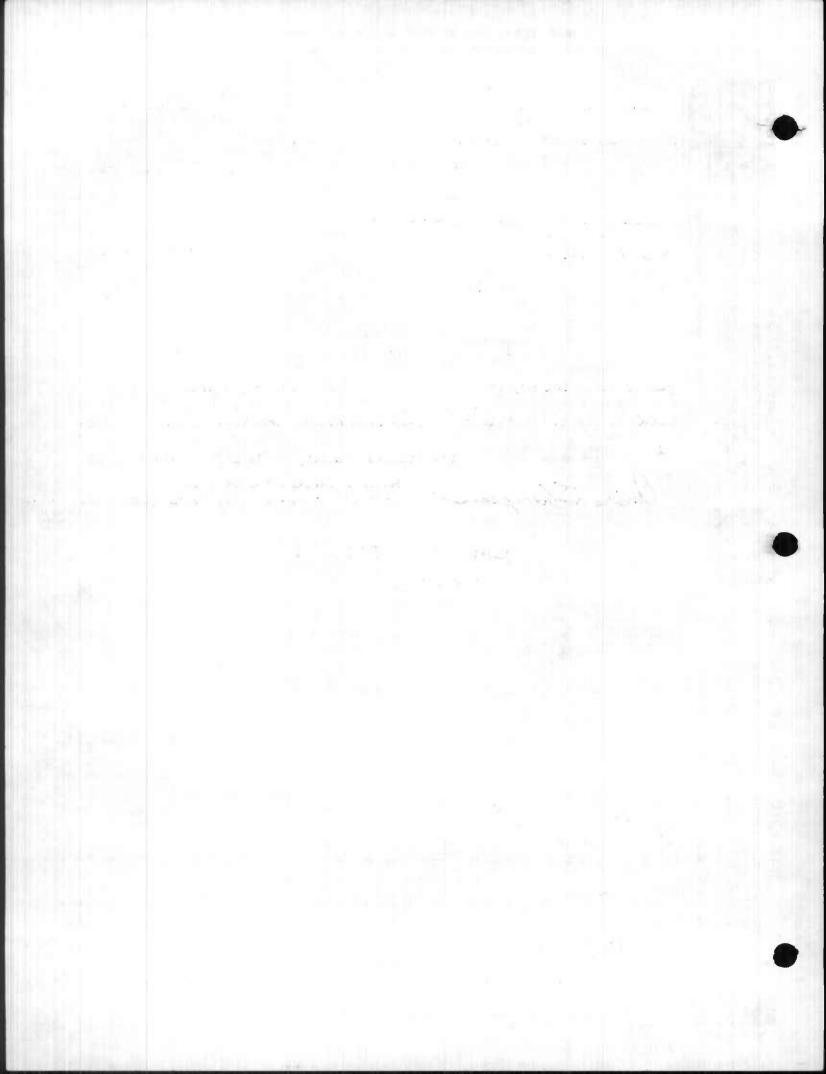
State Registrar 31. Data filed (Month, Day, Year) DEC 29 2000 32. Registrar's Signature

oaks



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent'a Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **Physician** December 22, 2000 Pamela Meyers Weems 2150 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Montgomery General Hospital Montgomery Olney If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Peb. 23, 1954 Washington, DC 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 ♥ F 46 Yrs 578-76-0125 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23s or 28s-f show 1 ☐ Yas 2 ☐ No Director Maryland Prince Georges New Carrollton 10g. Citizan of What Country? 10e Street and Number 10f. Zip Code death with 5913 87th Avenue 20784 United States Funeral 14. Raca - American Indian, Black, Whita, atc. 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry nd Mental Hygiene. marked other than Elamantary/Secondary (0-12) College (1-4or 5+) N/A 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Be h and Mental F 7 Is marked of Pages 1 and 2 should be nent of Health and Mental Edward Nathaniel Meyers Martha L. Wray 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) or other tra Martha L. Powell Mother 5913 87th Avenue, New Carrollton, MD 20784 20b. Placa of Disposition (Nama of cemetery, crematory or othar place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ♥ Burial 2 Cremation 3 Removal trom Stata 4 □ Donation 5 □ Other (Specify) Lincoln Cemetery 12/28/00 Brentwood, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Sarvice Licensee rompso 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical CARDIAC Examiner Due to (or as a consequence ot) Examiner SEPSIS physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in daath) Last Dua to (or as a consaquance of): Records, P.O. Box 68760. Physician/Medicai Dua to (or as a consequance of): ettending pl ed by the detached Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by a 1 Yee 2 No 3 Probably Unknown b 24b. Were autopsy findings available prior to completion of cause ot death? should ! 24a. Was an autopsy performed? Completed page 2 s 2KI No 1 Yes 1 ☐ Yas 2 ☐ No certificate Division of Vital or Attending Physician: Be 25. Was casa reterred to medical examinar? 26. Place of Death (Check only one) Hospital: 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) this 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Tima of Certification: After 1 Natural 2 ☐ Accident 5 Panding 1 ☐ Yes 2 ☐ No a Funeral Director: A sletely filled in by the fu death. Invastigation 6 Could not be datarminad 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. edicai 29a. Cartifier (Check only one) To the Vithin 2 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature and title of cartifiar 000 M.D., Ph.D. 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) KASID ROAD, ROCKVILLE MARYLAND 17519 REDLAND 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State 27 DEC Registra



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						C	ertific	ate of	Death		Reg. No.	1. 1. 2	910	
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Director		5. Social Security No. 178-54-6 Usual Residence of	413	Sex 7.	Age (In yrs.	last birtho	Mont	der 1 Yea hs Deys	r If Under 24 Hr	s. 8. Date of B	rth a <i>y, Year)</i>	9. Birthpla Countr New J	ice (State or F ry)	oreign
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death cer e attandin ed for use	Physician/			d										
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CHASE 1 6. Sex 1 M M M M M M M M M M M M M M M M M M	PRGES  #210  Was Decedent E Armed Forces?  I Yes, Give Yeer or Detes:  #200  **College (1-4or 5)  **HEFFR(1, Print)	e (In yrs. last b 84  10c. City, Tor  Ever in U.S. lo  166  19  20b. Place	Wn or Location  UPPER  10f. 2  13. Wes Dec If Yes, sp 1 Yes a. Decedent's Us (Give kind of wife. Do NOT HOLD)  b. Meiling Addre	MARL Zip Code  20 cedent of Hoecify Cubs 22A No sual Occup work done if use retired	dispanic Origin? (San, Mexican, Puer Specify: eation during most of word)  ER  18. Mother's Nei	s. Date of Birth (Month, Da) APRIL 1  specify Yes or No- to Rican, etc.)	Dey Ye 26, 200  4c. County of E PRINCE 9. 0, 1916  10g. Citizen of What U.S. 14. Rece - / Bleck, V Specify: 16b. Kind of Busine	Death  E GEORGES Birthplace (State or Country)  VIRGINI  10d. finside Cit  1X) Yes  at Country?  A.  American Indian, White, etc.
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	28e. Place of Injubuilding, etc	ury - At home, :. (Specify)	farm, streef, facto	ory, office				or Rural Route Num
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ying Physicis	wild illeriller ate	itou.	2	29c. Licens	se number		29d. Date signed (A	Month, Day, Year)
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ying Physicis at Examinet:	1 1 1	eath (Item 23a	(Type, Print)	111		1 1 1	710	M) 20
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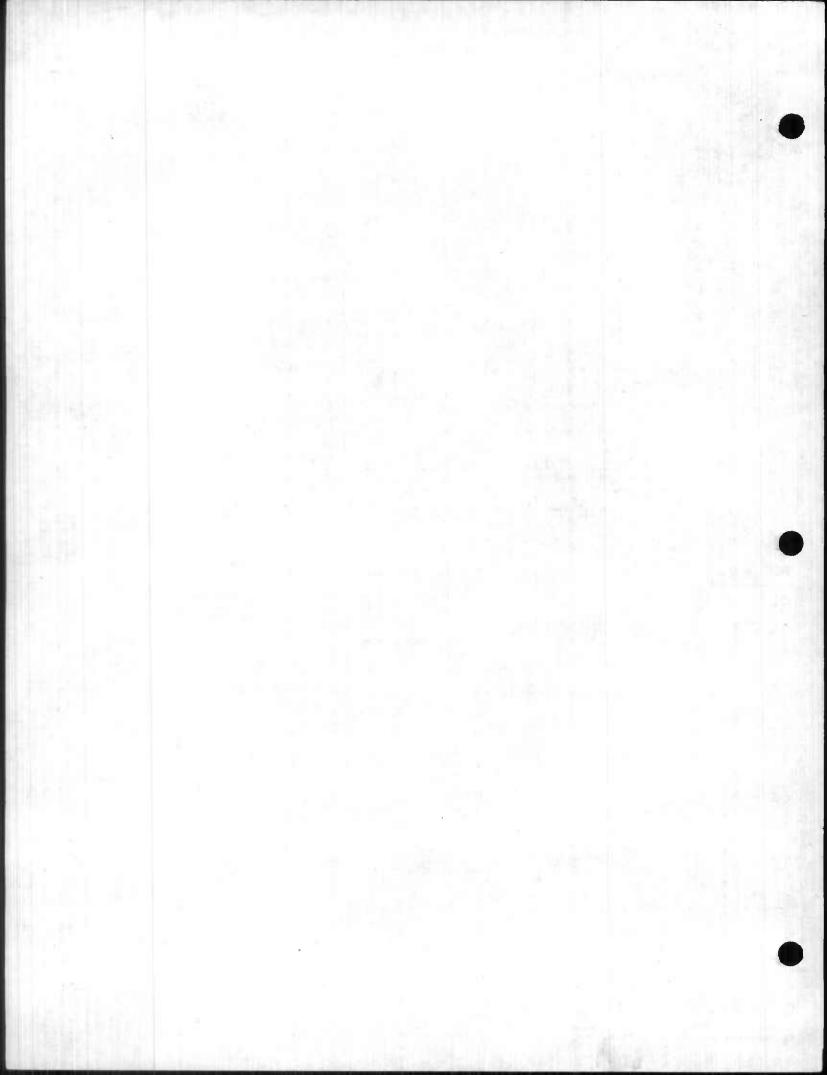
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	27 per ME G 1. Decedent's Nen	134	001				3. Time of Death				
ysician Medical	DOROT	DOROTHY WADLEY						Month DECEMB	Day SER21,200	7: 57 P.M.	
aminer	4a Facility Neme (If not institution, give street and number)						4b. City, Town, or	Location of Deal	th 4c. County of	of Deeth	
	HOLY CROSS HOSPITAL					If Under 1 Yes		SPRING		GOMERY	
eral ctor	5. Social Security I 262-38- Usuel Residence of	-4917	Sex 7. 1 □ M 2 1 F	7.7.90 (1.7.5. 1.00)			ar If Under 24 Hr.	8. Dete of Bi (Month, D SEPT.	oth ay, Year) 01,1931	9. Birthplace (State or Foreign Country) FLORIDA	
Important: if ten 27 is marked other than "natural", or fams 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at space.  To Be Completed by Funeral Director	10e. State	10b. County		10c. Cit	City, Town or Location 10d. Inside City Limits						
	MD	MONTGO	OMERY	ERY SILVER SPRING						1X Yes 2□ No	
	10e. Streef and Nu	5.41065	101. Zip (			Code		10g. Citizen of What Country?			
	10112	PORTLA	ND PLACE						USA		
	11. Meritel Stetus 1 ☐ Never Mar 3 ☐ Widowed	ried 2 Merried 4 Divorced	Armed Force 1 Yes 2	Armed Forces? If			Ves Decedent of Hispanic Origin? (Specify Yes or Yes, specify Cuben, Mexicen, Puerto Ricen, etc.)  Yes 2 No Specify:			No- 14. Race - American Indian, Black, White, etc.  Specify: BLACK	
	(Spe	15. Decedent's E		cetion 16e. Deceder		ent's Usuel Occupetion ind of work done during most of working			16b. Kind of Business/Industry		
	Elementery/Sec	ondery (0-12)	College (1-46 4YRS	College (1-4or 5+)			ind of work done during most of working ONOT use retired) STRATIVE ASSISTANT		GOVERNMENT		
	17. Fether's Neme (First, Middle, Last)						18. Mother's Name (First, Middle, Maiden Sumame)				
	SAMUEL WADLEY						LUE ANNA SCOTT				
	19e. Informent's N										
	20a. Method of Dis	IS KALLA	(SON)	20b. I	Plece of Dispos	sition (Neme of		Dete Dete		E, FL, 32277 City or Town, Steta	
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tor, p	25. Wes case refe	erred to medicet	26. Place of Deeth (Check only one)								
Jaip 5	axaminer?	] No	Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							ar (Specify)	
	27. Manner of Death  1 Neturel 5 Pending investigetic  3 Suicide 6 Could not determined					Injury et Work? 28d. Describe how injury occur		ed			
plately filled in by the funara edical Certification:			28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)				<b>&gt;</b> 0	281. Location (Street and Number or Rurel Route Number, City or Town, Stete)			
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of D	29b. Signaturg.ee	d title of certifier	111	. 1/			9c. License number		29d. Date signed (Month, Day, Year)		
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complate	The	oden s	1,600	Lu	1	0.0	C.M.E.		DECEMB	ER 24,2000	
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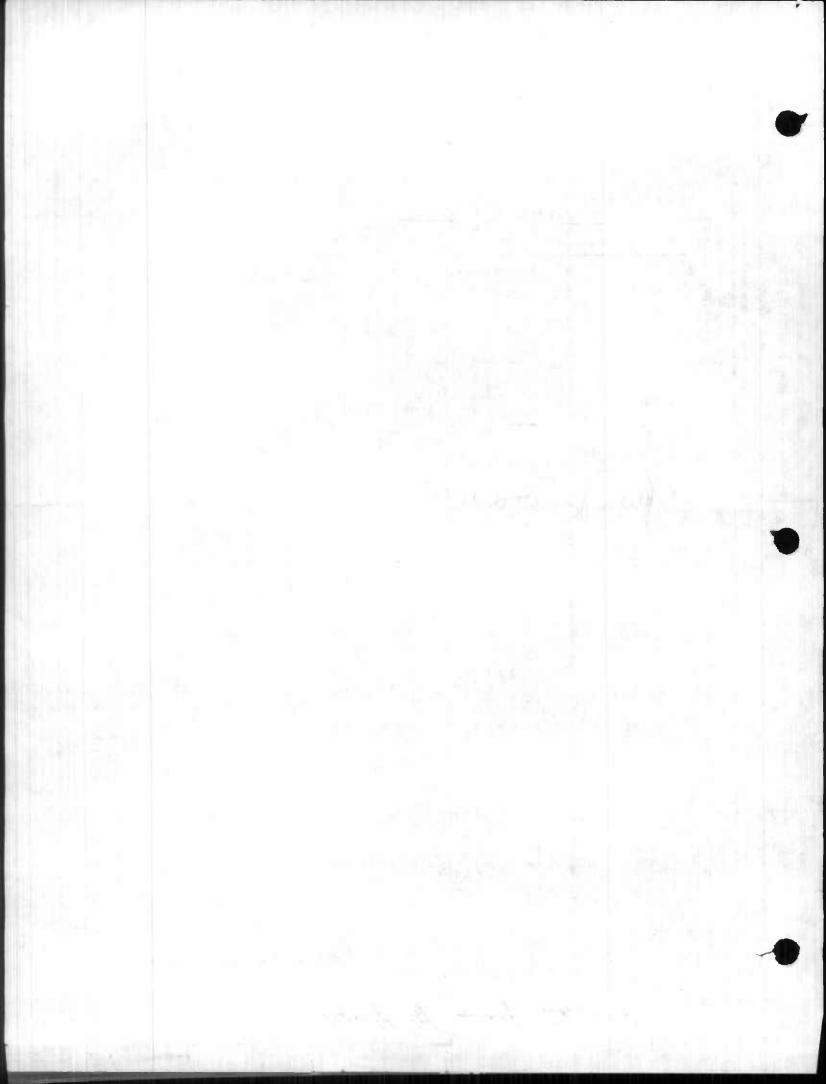
DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. amend item 19a,10e,f,10g per informant G7State of Maryland / Department of Health and Mental Hygiene amend item 23a,b per md G791 1/9/01 yf Certificate of Death 3. Time of Deeth Recedent's Nama (First, Middle, Last) 2. Data of Death **Physician** 3:20 AM 2000 O /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Nama (If not institution, give street end number, Examiner General olumbra Hospital Menus 8. Dete of Birth (Month, Day, Year)
Ian. 22, 1903 If Under 1 Year | If Under 24 Hrs. 7. Aga (In yrs. last birthday) 9. Birthplace (Steta or Foreign Country)
Mt. Hope, WV 5. Social Security Number 6. Sax **Funeral** Days Months Hours 1□M 2√2 F 97 232-62-7448 Director Usual Residence of Decedent Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28-f show eny Injury or other traumatic event, the Medical Examine. Insulia be notified. W Fayette County ¥E Yes 2□No Mt. Hope Funeral Director Columbia 10e. Street and Number 10a, Citizen of Whet Country? 10f. Zip Code 314 Mound Street 25880 West Virginia 6212 Stevens Forest Road USA 12. Was Decedent Evar in U,S. Armed Forcas? 1 □ Yes 24 No If Yas, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0020 1 Yas 2 No Specify: Specify: þ Black. 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) School Teacher Education 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Anthony T. Calloway Janie B. (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Great- Nephew Robert L. Lewis 6212 Stevens Forest Road Columbia, MD Baltimore. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 29 Nov. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donation 5 ♥Other (Specify)Entombment 2000 Blue Ridge Memorial Gdns Prosperity, WV 21. Signature of Funeral Service License 22. Name end Addrass of Fecility Metropolitan Funeral Service, Inc. 000ld2 5517 Vine Street Alexandria, VA 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner SEPTIC WITH A GASTROINTESTINAL INFECTION Sequentielly list conditions, if any, leeding to immadiata cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): burial-tran certificate be execu ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Dua to (or as a consequence of): The law requires that the de-23b. Did tobecco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ of Vital Records. 24a. Wes an autopsy performed? 24b. Were eutopsy findings available prior to Completed complation of causa of death? ual or Attending.

Its after death.

Ital Director: After this certificate has be established in by the funeral director, page 2 st 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicel axaminar? Be 26. Piece of Death (Check only one) Hospital: 1 Suppatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of injury 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding Investigation Division Matural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital e within 24 hours a To the Funeral D 29a. Certifie Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and member: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and member stated. Medical completely 29d. Date signed (Month, Dey, Year) 29c License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) me Columbia MD 210 MEDURSIQUOT mo lucu 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State NOV 2 9 2000 Registrar



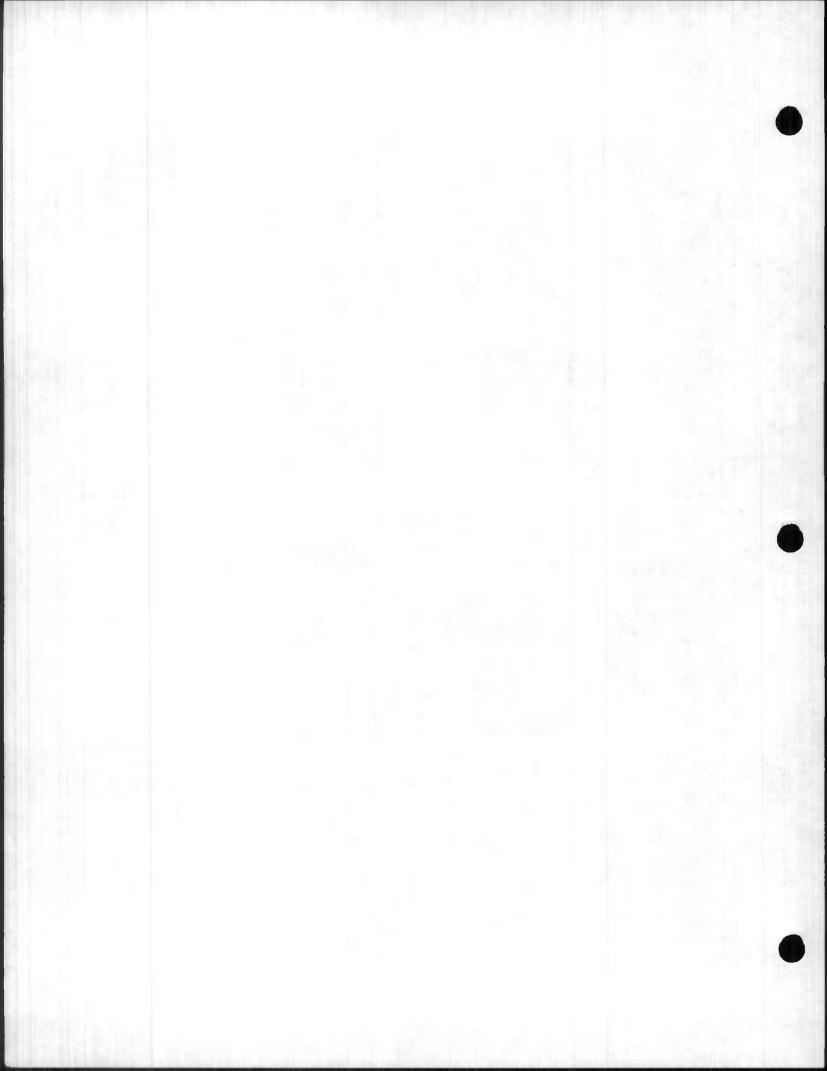
# VOID CERTIFICATE #

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CERTIFICATE M

01-31272



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Maryellen Chaney 1:00 AM December 10,2000 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kaltimore Franklin aquare If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) NOV. 24, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months Days Hours Maryland 55 1945 212-42-9396 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits it end 2 should be filed within 72 hours after death with the Merylar Health and Mental Hygiene. 1 Yes 2 No Directo Maryland Forest Hill Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Examiner must be 2009 Hialeah Court U. S. A. 21050 Funeral Honey, Mary 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☑ Married "natural", or 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed other than 'natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12th Grade Ticket Agent American Airlines 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be marked Louis V. Varacalle, Sr. Mary Ellen Serra 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Albert E. Chaney, Jr. (Husband) 2009 Hialeah Court, Forest Hill, Maryland 21050 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 Donotion 5 DOthor (Specify) Entombment Highview Memorial Gardens 12/14/00 Fallston, Maryland 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Schimunek Funeral Home Inc. 9705 Belair Road, Baltimore, Maryland 21236 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Physiciat /Neclical Immediate Cause (Final disease or condition resulting in death) Sxaminca Due to (or as e consequenca of). Examiner 19000C physician and the burial-transit deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): 980 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown been signed by should be detac þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed certificate has lirector, page 2 s 2 No 1 Tyes 1 ☐ Yes 2 No Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? Hospital or Attending 1 Netural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Diractor: / 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Placa of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is 1 Certifying Physicten: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) and menner steted. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature end title of cartifier

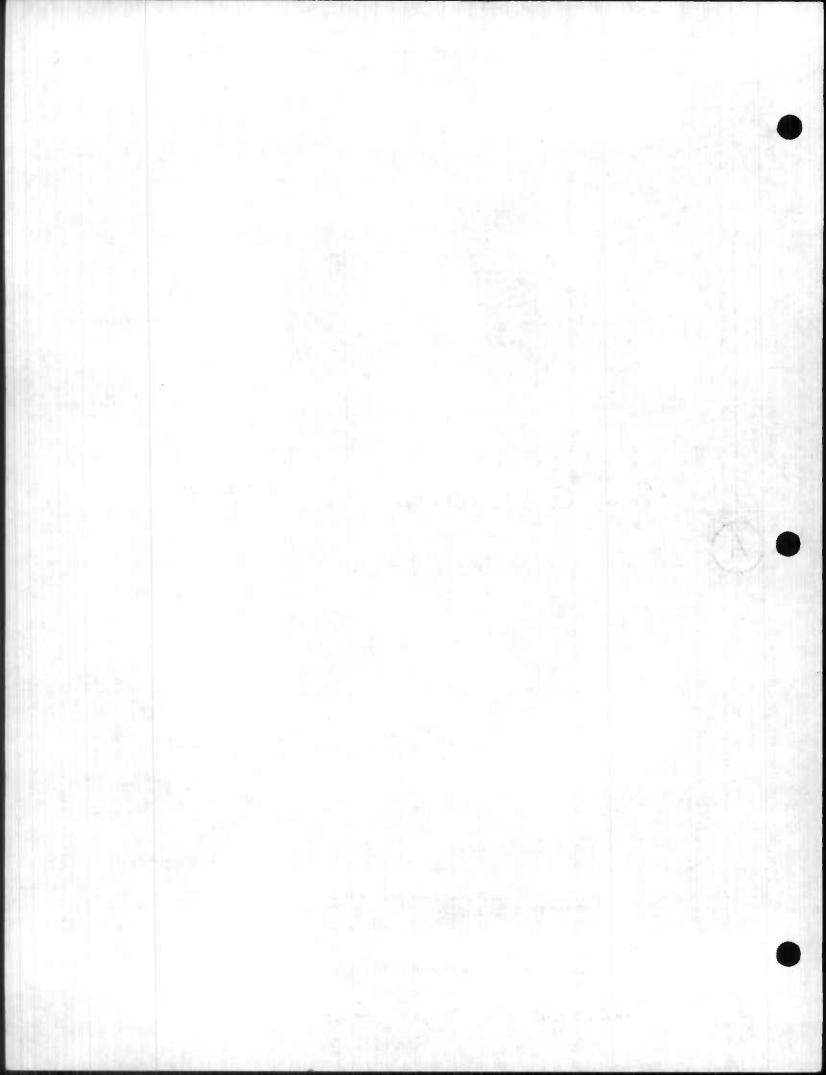
State Registrar 31. Dete filed (Month, Day, Year) **BEC 1 2** 2000

ennis odie mo

9000 Franklin Square
32/Registrar's Signeture

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

ware Drive Baltimore, Mary land



#### Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ( Certificate of Death 1. Decedent's Narge (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** lar 2 UNK. 00 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Ave Apt 1C Baltimore 1238 Rossiter If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M XXF Months Days Hours Yrs. Director 227-48-3204 Usual Residence of Decedent 05 N.C. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No NA Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 U.S.A. Ave Apt 1C Funeral 1238 Rossiter 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Detes: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: p 3 ☐ Widowed 4 ☑ Divorced Black Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 3yrs Nursing Support Technician John Hopkins Hosp 12th grade 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Samuel Jennings Margaret Barmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9046 Tarpleys Circle , Baltimore Md 21237 Nathaniel Brooks-Grandson 20b. Placa of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If ht any injury or o 12 Burial 2 Cremetion 3 Removel from State 4 Denation 5 Other (Specify) Cedar Hill Cemetery 1/5/01 Pikesville, Md 21. Signature of Funeral Service Licans 22. Name and Address of Facility March F/H West MACH 4300 Wabash Ave, Baltimore Md 21215 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine TO POVES I Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last diabetes Physician/Medical Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 DOnknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 1 Yes 2 19 10 1 Yes 2 → No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specity) 1 Yes 2 No 10 27. Manner of Death 1 Netural 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of Cartifier 29d. Date signed (Month, Day, Year)

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Registrar

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To the Hospital within 24 hours a To the Funeral I

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Division Attending

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. 51550n MB N. Caroline 601

Stephen 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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the Maryland

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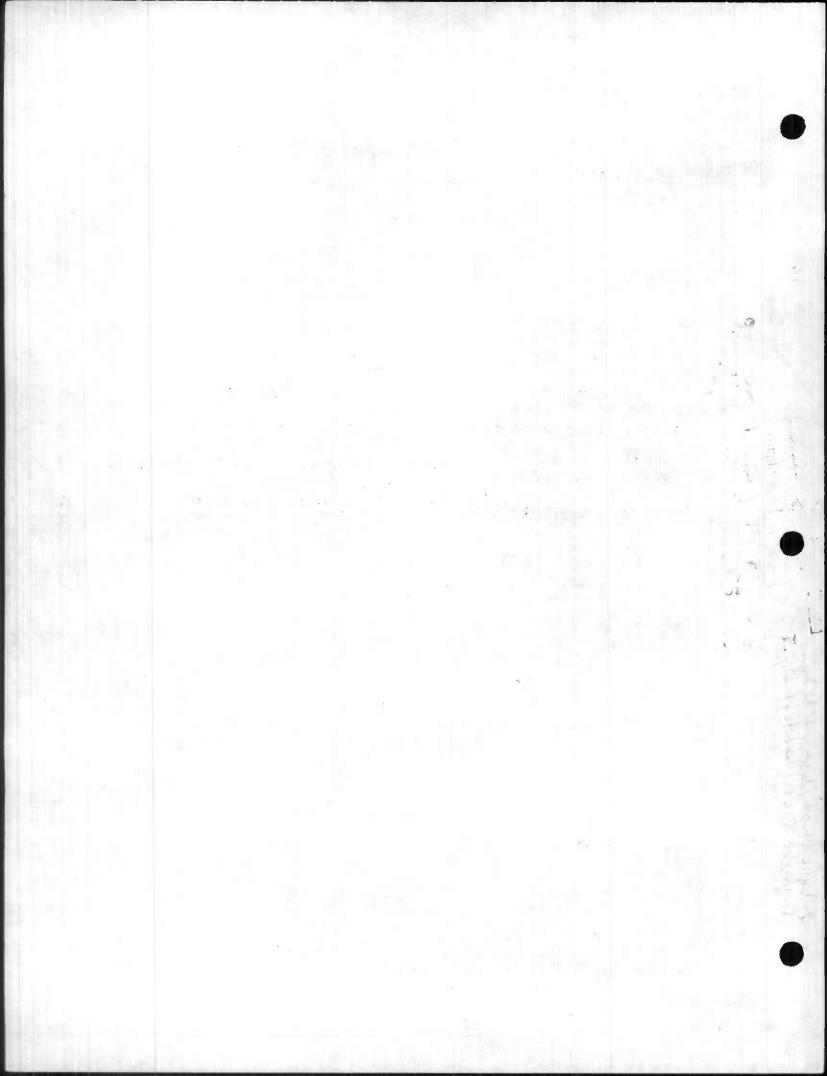
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Pages 1 and 2 sinnent of Health an

3altimore, Maryland 21215-0036

7 is marked other than "natural", or frame 23s or 28s-4 show traumatic avent, the Magical Examinar must be notified at



Please Type or Print in Black Indelible ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#23a perPHYG791 1/10/01 EW 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Joseph T. Durham, Jr. December 26, 2000 pation of Death 4c. County of Death 0220 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number, PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 154-24-2711 Days Hours 1X M 2□ F 65 Yrs. February 20, 1935 Usual Residence of Decedent 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits Wicomico Sharptown XX Yes 2 No 10e. Streel and Number 10f. Zip Code 10g. Citizen of What Country? 300 Joe Morgan Road 21861 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, alc.) 12. Was Decedant Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. 11, Marital Status NOTYes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☒️ Specify: Specify: White if Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trick Driver Transportation 10 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph T. Durham, Sr. Claire L. Ourley 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marva J. Durham / Wife PO Box 128 Sharptown MD 21861 20b. Placa of Disposition (Name of camatery, crametory or other placa) 20c. Location - City or Town, Stata 20a. Malhod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lawnside Cemetery December 29, 2000 Woodstown, NJ 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Fyrand Service Losses Victor P. Doch, Jr. 22. Nama and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death COPD Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): RESPIRATORY Failure Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thal initiated avants resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Whiknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 25€No 25. Was case refarred to medical examiner? 26. Place of Death (Check dnly one)

Physician /Medica: Examiner Programmer

Box 68760,

P.O.

Records,

of Vital Physician:

Division or Attending **Physician** 

/Medical

Examiner

MD

**Funeral** 

Director

the Medical Examiner must be notified at

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Il Hygiene.

permit. Pages 1 and 2 should be fill Department of Haelth and Mental Hy moortant: If flem 27 is marked oth easy injury or other traumatic event

| Dur ham | Maryland 21215-0020

Funeral Director

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Completed

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Physician/Medical Examine Be After this after death.

ρ Completed

Medical Certification: To

27. Manner of Death 2 Accident 3 ☐ Suicide 4 | Homicide 29a. Certifier

31. Dale filed (Month, Day, Year)

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tille ontitie

6 Could not be

Hospital:

5 Pending invastigation 28e. Pleca of Injury - Al homa, farm, street, factory, offica building, etc. (Specify)

28a. Dete of Injury (Month, Day Year)

28c, injury at Work? 1 Yes 2 No

28b. Time of

1 Inpatient 2 ER/Outpatient 3 DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

इरमार्च रहा

29c. License number 1454827

Metary ST

29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 26 166 GITTELMAN 1 weather

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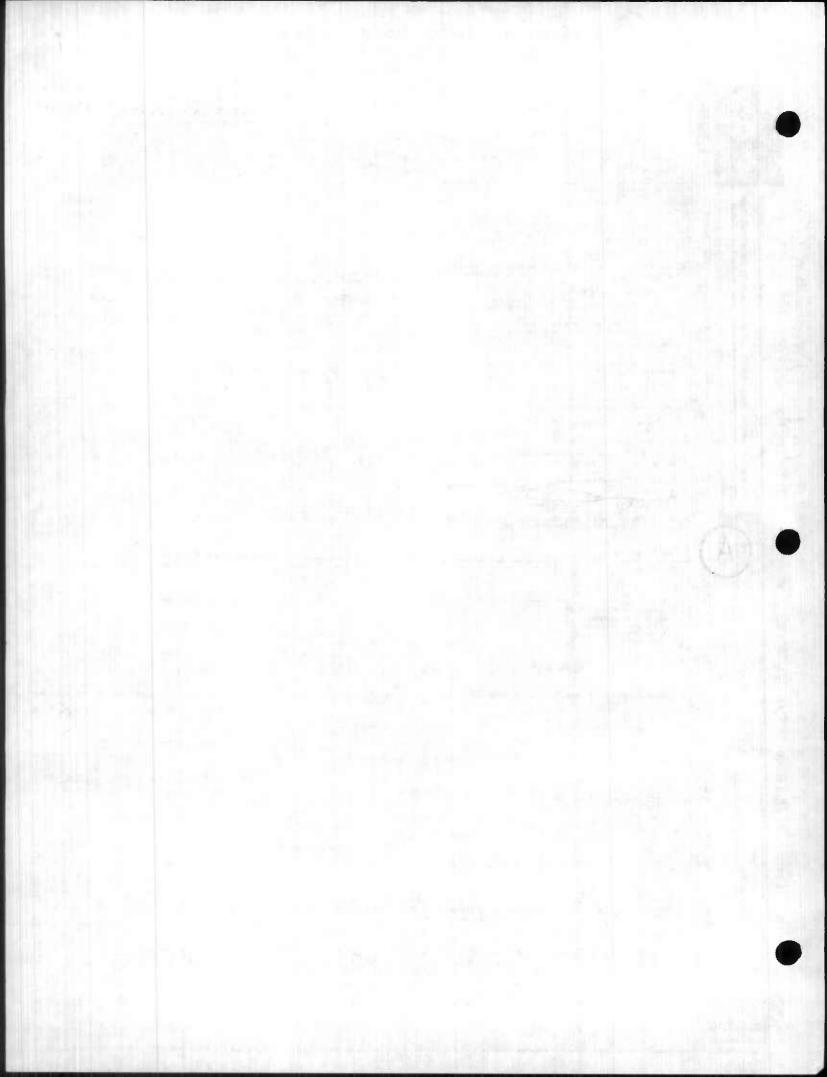
32. Registrer's Signature

within 24 hours a To the Funeral I Hospita

To the

completely

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $\mathbb{U}$   $\mathbb{U}$ AMEND FIFM: #1 PER PHY G791 1-10-2000 WR. Certificate of Death FRANCIS SERVICED DECKORIE 1. Decedant's Nama (First, Middla, Last) 2. Date of Death Month **Physician** December Tancis Sherwood 6:00a, m 29 2000 /Medical 4a. Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** 7811 Highpoint Rd. Parkville Baltimore Co. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Jan . 3, 1910 5. Social Sacurity Number Birthplace (Stata or Foreign Country) 6. Sex 7. Aga (In yrs. last birthday) **Funeral** XXM 2DF 90 217-22-1909 Vrs Director NY Usual Residence of Decedant the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits d 2 should be filed within 72 hours efter death with the Maryle it and Mantal Hygiane.
It americed other than "natural", or items 23s or 28s-f show traumatic avent, as seed as Examine toward, as seed as Examine toward. Baltimore Parkville 1 ☐ Yes XXNo Director 10f. Zip Coda 10e. Street and Number 10g. Citizan of What Country? 7811 Highpoint Rd. 21234 USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Year or Datas: 14. Race - American Indian, Black, White, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: white by 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Eiamentary/Secondery (0-12) College (1-4or 5+) Fed. Gov't. Policy analyst permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If flam 27 Is marked other any injury or other traumatic avent, since. 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) Be August J. Deckert Anna Denzel 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Elizabeth D. Bastio-daughter 7811 Highpoint Rd. Bal. MD 21234 20a. Method of Disposition

1 Buriai 2 Cremation 3 Removal from Stata 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem.Grds.1/3/01 Cockeysville, MD 21. Signatura of Funarai Sarvica Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, 6500 York Rd. Baltimore, MD 21212 23a. Part1. Enter the disaasa, or complications that caused the death. Do not antar tha mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Physician Down /Medical Immediata Causa (Final disease or condition rasulting in death) Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immadiata ceuse. Entar Undarlying Cause (Disaase or injury that initiated evants rasulting in death) Last Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical Due to (or as a consequance of) signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementia hypothyroidism, renal 24b. Wera autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Stroke, Coronary aftery disease 1□ Yas 2□No certificate 1 □ Yas 2 □ No or Attending Physician: Be 25. Was cese referred to medicel axaminar? 26. Placa of Death (Check only ona) Other: 4□ Nursing Homa 5 □ Hesidance 6 □ Other (Specify) Certification: To 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred Aftar 1 ( Natural 5 Panding death. 1 ☐ Yas 2 ☐ No invastigation 2 ☐ Accidant after death Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Ptace of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 24 hours Hospital 1 Certifying Physician: To tha best of my knowledge, daeth occurred at tha tima, date and place, and dua to the causa(s) and menner as steted. 29a. Certifian Medical (Check only one) 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. T T 29b. Signatura and titla of comple 29c. Licanse number 30. Nama and address of person who complated ceusa of death (Item 23a) (Type, Print) Klin Square 32/Ragistrar's Signature

**DHMH 16 Rev 6/95** 

State Registrar

31. Data filed (Monti

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 4 2 9 1 9 Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Felix Eugene Helm; 4a Facility Name (If not Institution, give street and number) 17:25 Helmick 2000 2 30 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 23, 1 Baltlnore City Veterans Hosp/tal Baltimore 6. Sex 1 ☑ M 2 ☐ F 9. Birthplace (State or Foreign Country) 1923 West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 77 Yrs. 235-20-1935 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1X Yes 2 □ No 10f. Zip Coda 10g. Citizen of What Country? 10e. Street end Number 2313 Sidney Avenue 21230 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) floor person box warehouse 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Debbie Locklear/step daughter 3929 Mt. Pleasant Avenue Baltimore, MD 21224 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremation 3 Removel from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, Director 22. Name end Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Batwean Onset end Death Immediate Cause (Final disease or condition resulting in daath) . Chronic Obstructive Pulmonary Disease Due to (or as e consequence of): Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initieted evants resulting in death) Lest Due to (or as e consequence of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 Type 2 No 24b. Were autopsy findings evailable prior to 24e. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 26. Place of Daath (Check only one) Hospital: Othar: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be detarmined

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**Funeral** 

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altimore, Maryland 21215-0020

7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at

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permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: if Item 27 is marked oth eny injury or other treumatic event page.

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25. Was case raferred to medical 1 Yes 2 No 27. Mannar of Death 1 Matural 2 Accident 3 ☐ Suicide

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28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 29a. Cartifian 1 Certifying Phyelotan: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check only one)

29b. Signature

29c. License number

29d. Date signed (Month, Day, Year) 12,30,2000

30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) JAMES MAXWELL LAI

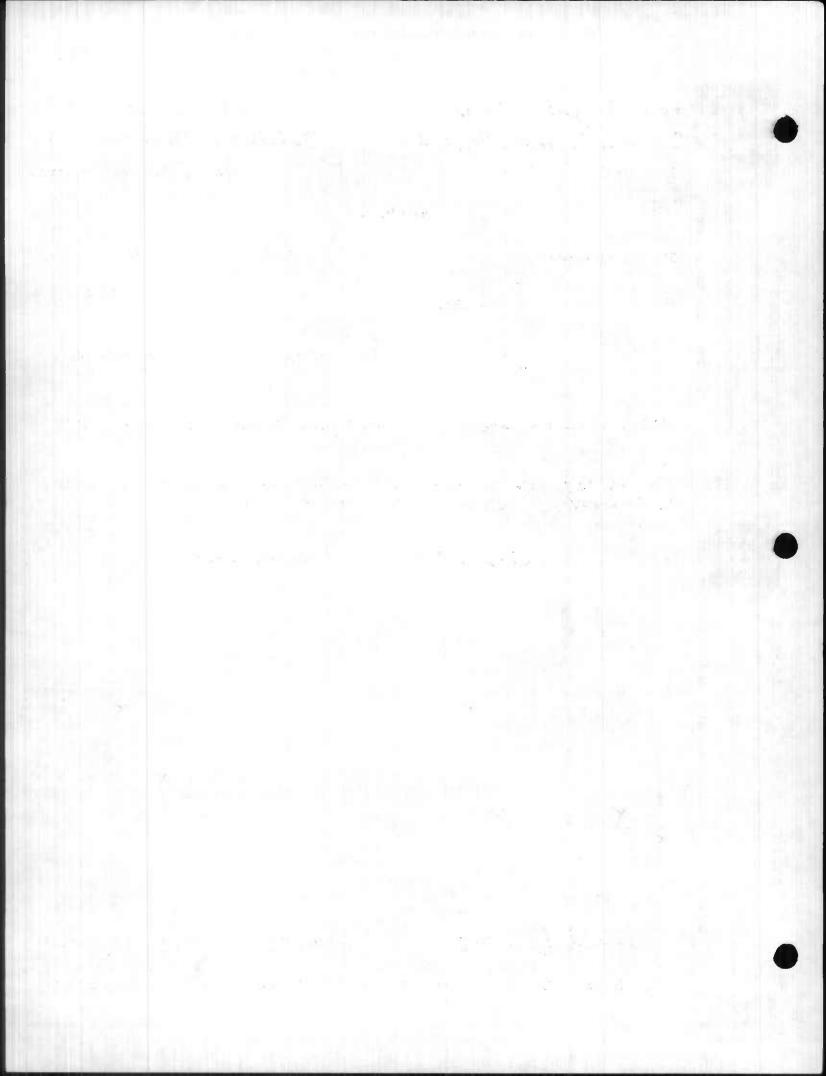
10 North Greene Street BALTIMORE VETERANS HOSPITAL

Registrar

31. Date filed (Month, Day, Year) JAN 1 0 2001 32. Registrar's Signature

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To the Hospital o within 24 hours of To the Funerel D



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Physician 26 /Medical Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Millennium Health Center Baltimore N/A | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year 10/25/19 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 200F 81 **Director** S. Carolina death with the Maryland 10a. State 10b. County Show 10c. City, Town or Locetion 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Marital Hygiene.
Important: if Health areked duter than "natural", or Rema 23a or 28a-f show any Injury or other traumatic event, In Madical Examinet matter profitted. Director 1 Yes 2 □ No Md. Baltimore 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? 3135 McElderry St. 21205 Funeral USA 11. Marital Status 12. Was Decedent Ever in U,S. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Armed Forces?

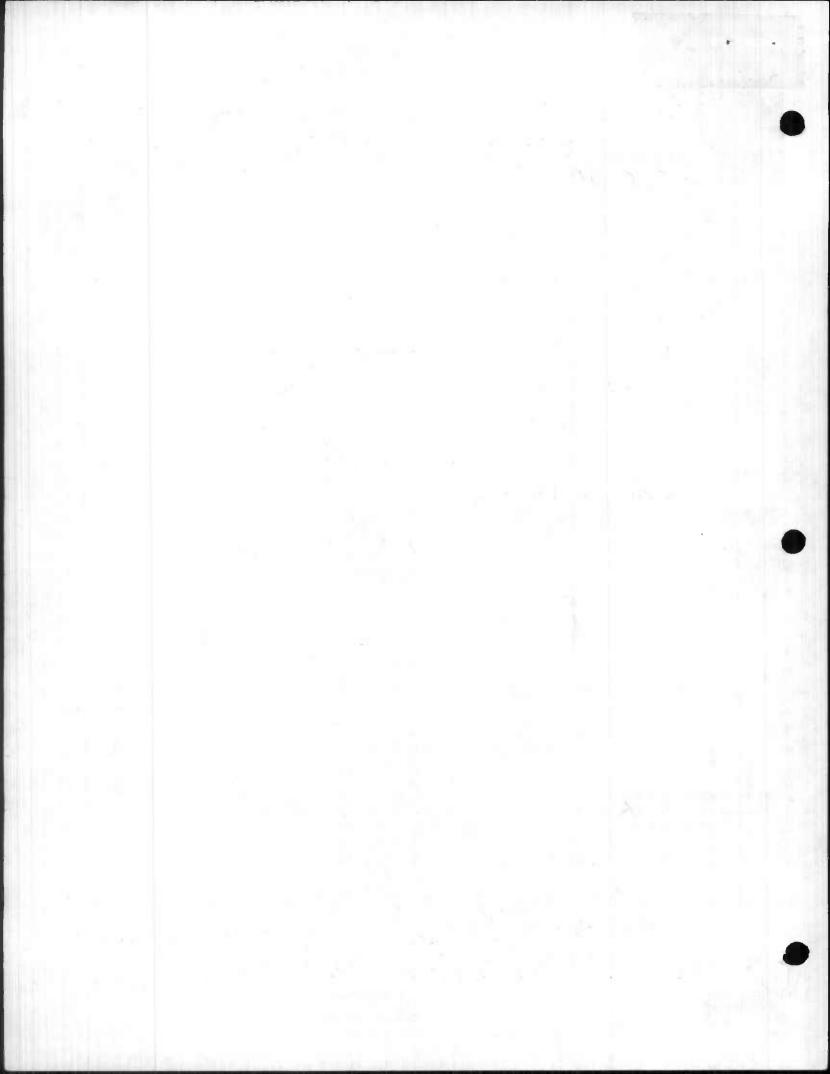
1 Yes 2 No
If Yes, Give Bleck, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 21XNo Specify Specity: Black by 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates Completed 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Unknown 0 Unknown 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mildred Colbert 3135 McElderry St, Baltimore, Md. 21205 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) Dete AN 14 20c. Location - City or Town, Stete 20e. Method of Disposition Metro Crematory, INC. Catonsville, Md. 22. Name end Address of Fecility Estep Brothers Funeral Ser, P.A. 21. Signature of Funeral Service Licensee 1300 Eutaw Place, Baltimore, Md.
Do not enter the mode of dying, such as cardiac or respiratory errest. 21217 23a. Pert1. Enter the declaration or complications that caused the death. shock, or heart factors. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner The law requires that the deeth certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest pue buriel-tran Due to (or es a consequenca of): P.O. Box 68760. physician ettending physics for use es the Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. ate hes been signed by the page 2 should be deteched 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ Completed 24e. Wes en eutopsy performed? Were autopsy findings aveileble prior fo completion of cause certificate hes 1 ☐ Yes 2 ☐ No of Vital Attending Physician: director, 25. Wes case referred to medical exeminer? Be 26. Piece of Death (Check only one) Other: 1 Yes 20 No Medicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) vours efter death.

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filled in by the funerel di this 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 | Homicide 6 To the Hospital o within 24 hours of To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and # 29d. Date signed (Month, Day) Year) 31. Dete filed (Mon

32. Registrer's Signeture

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State Registra



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 51MPSON Month **Physician** 12:01 KM 12 26 00 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY MD GEORGE'S PRINCE 8. Date of Birth (Month, Day, Year) May 20, 1928 If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country)
 WI 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Days Min. 1 M 2 X F 128-46-1769 72 Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits NY Kings Brooklyn 1X Yes 2 □ No Director r than "natural", or items 23s or 28s-f the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 217 Chauncey Street 11233 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 🖾 No Specify: à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 Cleaner Apparell Processing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be financial by the marked of 20 Timna Parkinson Joseph Gayle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1 and 2 4 Department of Health a freportant: If them 27 ha 18 East 19th Street, Brooklyn NY 11226 Janet M. Ford-Douglas/ Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State 8 1/2/2001 4 ☐ Donation 5 ☐ Other (Specify) Fresh Pond Crematory Queens, NY Charles L. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stevens Funeral Home, Inc. 21230 any is 1501 E. Fort Ave. Baltimore, Victor P. Doda, Jr. Per DVR 23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each lina. Approximate Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner ician and buriel-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last certificata be exec physician Physician/Medical tha as esn 0 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. tha detached signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? paga 2 certificata has 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicel examiner? director Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Dey Year) funeral 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? After Certification: Attending 1 Natural 5 Pending or Attending after death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours a Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical pletary To the To the To the

State Registrar

Maryland 21215-0020

Baltimore,

Box 68760.

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Records,

Division of Vital

31. Date filed (Month, Day, Year) JAN 10

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ss of person who

29b. Signature at

3001 FIERSON 32. Registrar's Signature

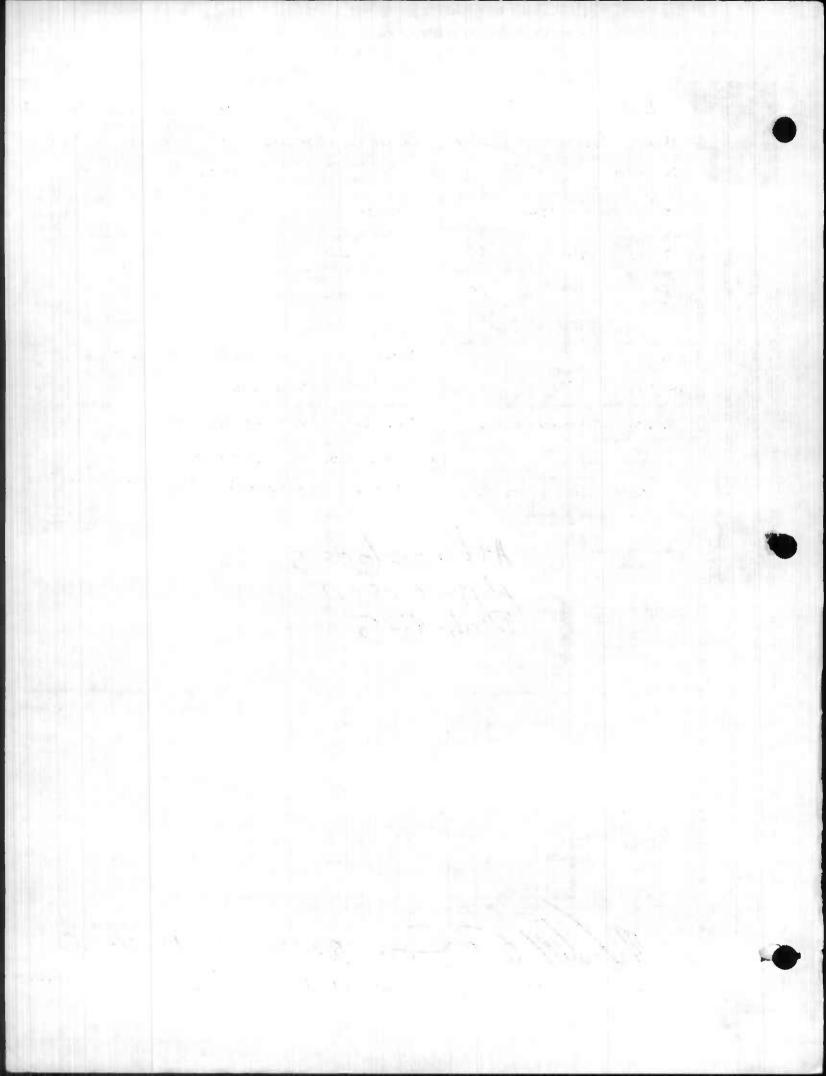
completed cause of death (Item 23a) (Type, Print)

HOSPITAL parks

29c. License number

29d. Date signed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

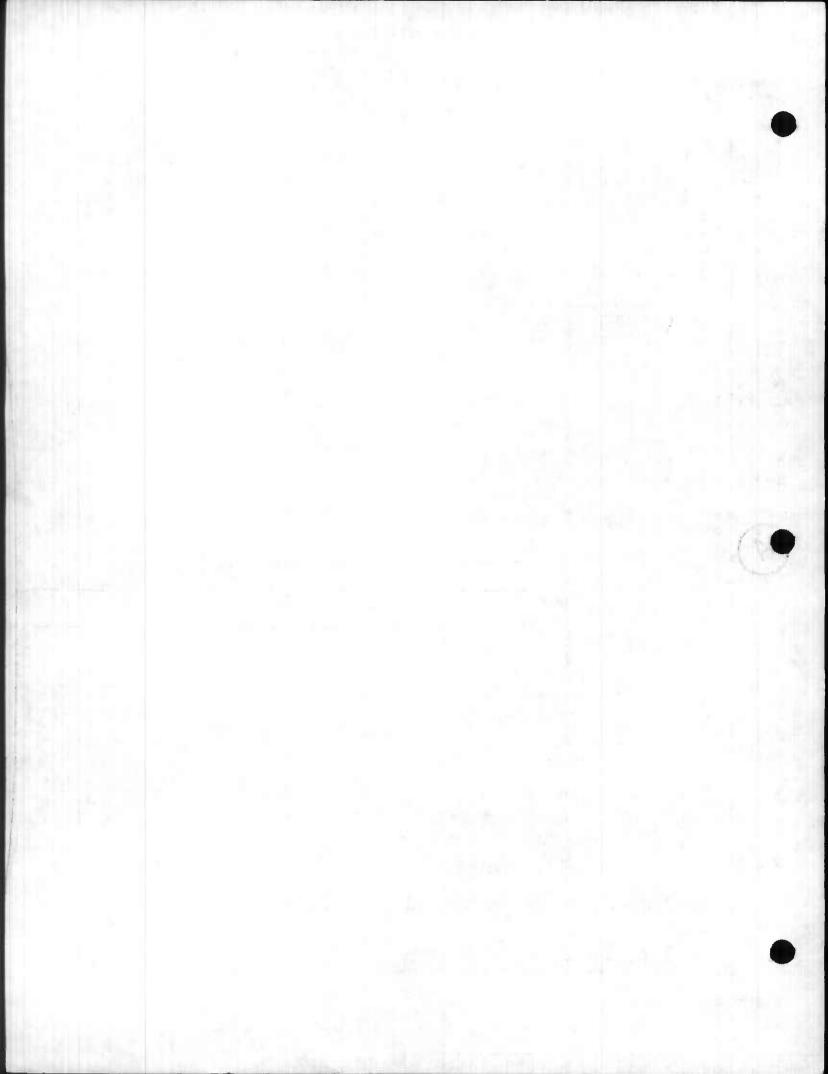


AMEND ITEM: 18 PER F.H. G791 1-17-State Not Maryland / Department of Health and Mental Hygiene | Amended Item#23a perPHYG791 1/10/01 EW Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 0645 pm ) ILLIF ,2000 Decomber /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore V.A. Medical Baltimore Baltimore Center If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** Deys Hours Min 1**5€**M 2□ F Yrs. 11/15/1923 Director 458-24-4062 Usuel Residence of Decedent TX 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits tran "natural", or items 23e or 28e-f sho the Medical Examiner must be notified at 1 Yes 2 No MD Baltimore Woodlawn Directo 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7508 Heatherfield Drive 21244 USA Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Dives 2 No
If Yes, Give
Year or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify À 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h, Kind of Business/Industry a filed within 7. al Hygiene. I other than "ru Elementery/Secondary (0-12) College (1-4or 5+) Self Employed Night Club 8. Mother's Name (First, Middle, Maiden Sumeme) ANNIE MONROE 17. Fether's Neme (First, Middle, Last) Be should be ind Mental is marked Earnest Taylor 2 Anne Monroe permit. Pages t and 2 sh Department of Health and Important: if then 27 is im any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladdis Taylor Daughter 7508 Heatherfield Drive Baltimore, MD 21244 20b. Ptece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donetion 5 DOther (Specify) Fort Sam Houston Nat. Cem 12 19 San Antonio, TX 21. Signature of Funeral Service Lice 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. [ who 736 Edmondson Ave. BAltimore, MD 21228 Approximete Interval Between Onset and Death 23a. Pert1. Enter the disedse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Phys cian Pseudomonas Immediate Ceuse (Finel disease or condition resulting in death) /Medical days Examiner 2 Months CEREBROVASCOLAR ACCIDENTS Examiner sician and bunal-trans Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last Due to (or es e consequence of) signed by the ettending physician I be detached for use as the buna Box 68760 Physician/Medical Due to (or es a consequence of): Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ cete hes been significant page 2 should b 24b. Were eutopsy findings aveileble prior to completion of ceuse of death? 24a. Wes en autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No this certificete after death.

Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner steted. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier GM 30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print)

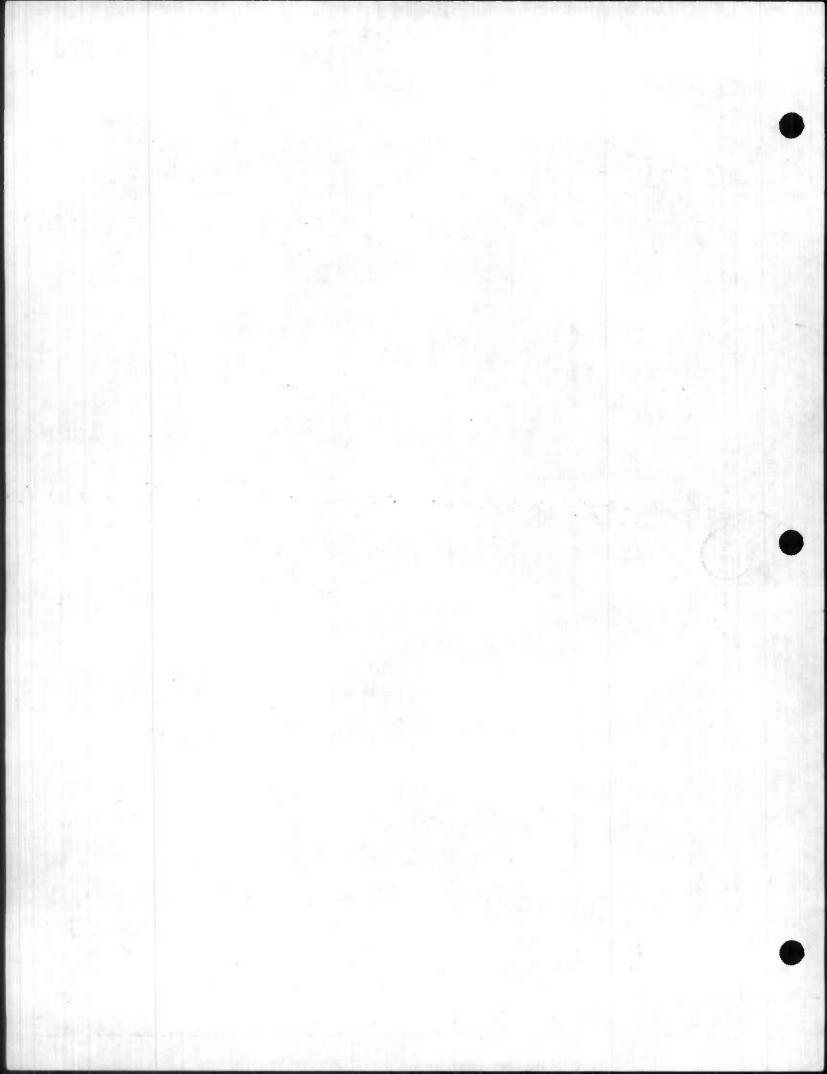
Stephen Swmws 22 South Bultimore MD 21201 Greene Street Stephen 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien AMEND#5 PER F.H. AND Certificate of Death AMEND#23 PER MD. G791 1-11-2001 JAB 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Year Physician 6:25AM TEOROG orner recomber 21 2000 imoth /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner JOHN HOPKINS Bay 1/16) HOSP. BALTIMORE BALT MI If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) February 6,1924 New York 6. Sex 12 M 2□ F 7. Age (In yrs. lest birthday) 5. Social Security Number **Funeral** Yrs. Director Usual Residence of Decedent 10a. Stete 10d. Inside City Limits 10b. County 10c. City. Town or Location 14 Yes 2 No herne 23e or 28e-f et ner must be notified Directo Baltimore Maryland n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 1213 Dundalk Avenue United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2□No If Yes, Give Year or Dates: ₩₩ II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Merried Specify: White Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Arlington United Hygiens. Elementary/Secondery (0-12) College (1-4or 5+) 4 Minister Methodist Church vears 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H ant; if them 27 is marked off Be Josephine Timothy Carney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stefe, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1213 Dundalk Avenue Baltimore, MD 21222 Wife Shirley Foxwell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 17☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Document it any injury o Woodlawn Memorial Park Dec. 23, 2000 Easton, Maryland 22. Name and Address of Fecility Loring Byers Funeral Directors, cellor Moo333 8728 Liberty Road Randallstown, MD 21133-4784 or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical 21) days ultiorgan Ezaminer Due to (or as a consequence of) Examiner ACUTE RENAL FAILURE death certificate be executed physicien and the burief-tran Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Disease or Injury that in the lease or Injury Due to (or es e consequence of) Box 68760. MYOCARDIAL INFARCTION Physician/Medical that initiated events resulting in death) Last Due to (or es e consequence of) for use as S 23b. Did tobacco use contribute to the cause of death? ed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings evailable prior to completion of cause of death? should b 24a. Wes en eutopsy performed? Completed has 10 2 page 1 Yes 2 No 1 ☐ Yes 2 No certificate Physician: 25. Was cese referred to medicel director Be 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2⊟No 10 1 DImpatient 2 ER/Outpatient 3 DOA this After this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: or Attending 5 Pending Investigation 1 Natural death. 1 TYes 2 □ No Director: / 2 ☐ Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 ☐ Homicide after To the Hospital o within 24 hours af To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

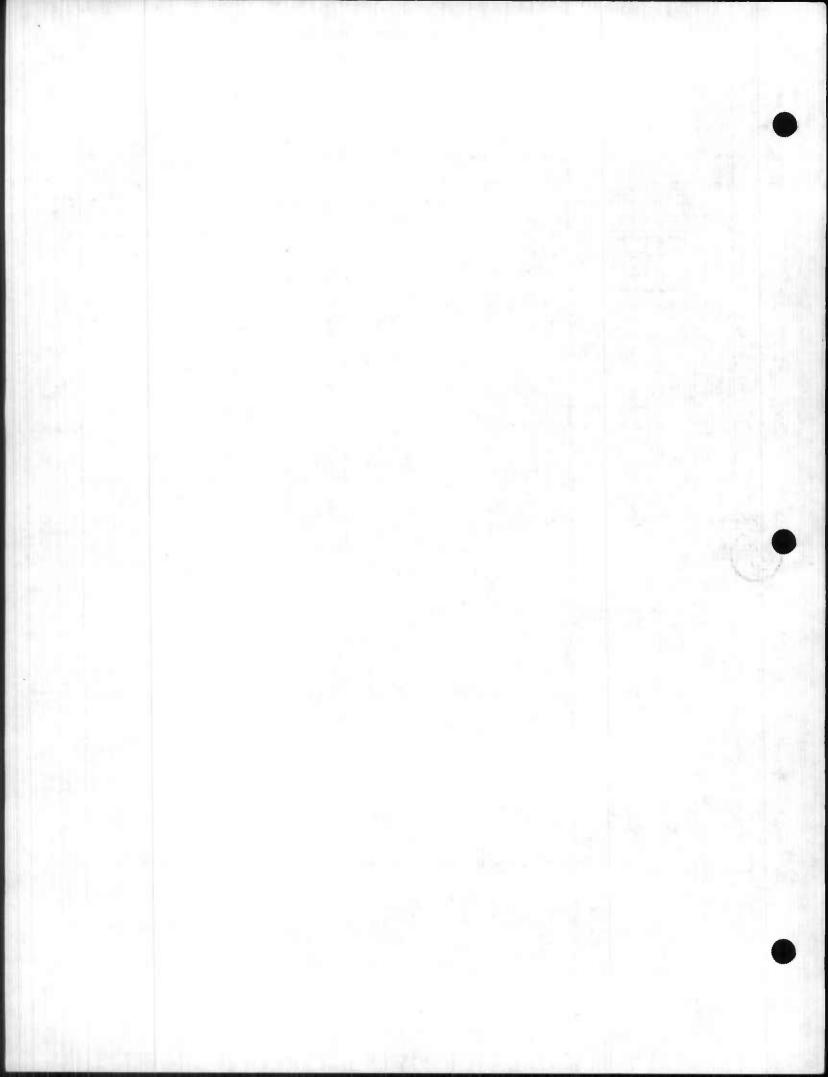
2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Party Chi, MD Baltimore Hospital 4940 Fastern Baynew tienue 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State DEC 2 9 2000 Registrar DHMH 16 Rev 6/95

**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#23a&c PER MD. G791 1-11-2001 JAB 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death pm **Physician** HUNDERIMARIC MMA 2 22 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) Examiner MASADEN A Oak Lodge Assisted Living If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Sacurity Number Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days 1 M 2 F 578 03 2668 94 Yrs. Director March 6, 1906 Maryland Usual Residence of Decedent 10e. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or flame 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 200 No Anne Arundel Maryland Pasadena Director 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 7755-A Outing Avenue 21122 U.S. death Funeral 14. Raca - American Indian, 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status Black, Whita, etc. hours after 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify. P 3 Widowed 4 □ Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grada completed) filed within 72 Hygiene. Elementary/Secondary (0-12) Cotlega (1-4or 5+) Homemaker Own Home 12th permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Moortant: If Nem 27 is marked other any injury or other traumatic event. 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) George Tighe Dora Hopf 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Linda Wright / Niece 840 Kecoutan Road Glen Burnie, Maryland 21060 20b. Placa of Disposition (Name of cematary, cremetory or other placa) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 12/27/00 Baltimore, Maryland Baltimore Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 ma ramerousa fications that causad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, ne cause on each line. 23a. Part 1. Entar tha disaa or of shock, or haart failura. Intarval Batween PNEUMONIA. RECURRENT Onsat and Daath Physician Medical Immediata Causa (Final disaesa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disaase or Injury that initiated evants rasulting in death) Last and Box 68760. attending physician certificate be Physician/Medical es the Dua to (or as a consequence of 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 100 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed by Division of Vital Records. by 2 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pege 2 should Completed has 1 Yas 2 No 1 ☐ Yas 2 ☐ No this certificate Attending Physicisn: 25. Was casa rafarred to medical Be 26. Placa of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Homa 5□ Rasidenca 1 Yas 2 No 6 DONNE Lo 28d. Dascribe how injury occurred 27. Manper of Death 28b. Tima of After 5 Panding invastigation Netural death. 1 Yas 2 No 2 Accident i or Attend after death Director: / 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 6 Could not be datamined 3 Suicida 28a. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end plece, and due to the causa(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and titlerof cartifiar of person who complated causa of death (Item 23e) (Type, Print) NAMOUS OBLY 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar

DHMH 16 Rsv 6/95



Please Type or Print in Biack Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Year Month **Physician** 4:00 PM JACK PRESTON DEZ. 9-000 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) CHINS BAUTIMODE COURT 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) **Funeral** Days 10M 20 F Yrs. 235-28-3687 SEPT. 20,1923 Director W. VIRGINIA Usual Residence of Decedent the Marylend 10a. Slala 10b. County 10c. City. Town or Location 10d. inside City Limila 1 Yas 2 No Directo MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ms 23a or with U.S.A. CHINS COVET 21117 Funeral death "netural", or itsms 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 by Specify: 3 Widowed 4 Divorced WHITE the Medical Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BAUTIMORE Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. COUNTRY CLUB MANAGER 15 +2 COUNTRY CLUB 7 is marked other traumatic svent, 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Surnama) Peges 1 and 2 should be filt ment of Health and Mental Hy and: If item 27 is marked oth jury or other traumatic svent Be 2 PEARL B. RING JAMES PRESTON MYERS 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrasa (Street and Number or Rural Route Number, City or Town, State, Zip Code) REGINAT, MYERS, 31 CHINS CT. ONINGS MILLS, MD. 21117 SPOUSE 20b. Plece of Disposition (Name of cemetery, crematory or other place)

EVANS FUNDEM CHAPET 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State JAN 5 permit. Page Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) 1006 FOREST HILL, MD. 21. Signalura of Funeral Service Licenses 22. Name and Address of Facility EVANS FUNERAL CHAPEL Reson Z SSOO HARFORD RD. PARKVILLE, MD. 21234 cations that caused the death. Do not entar tha moda of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical JEPS15 Examiner Due to (or as a consequence of) Examine angrewe death certificate be executed physician and s the burial-trans Sequentielly list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Due to (or as e consequence of): Box 68760 Physician/Medicai Due to (or as e consequence of): for use as t signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? been si Completed 24a. Was an autopsy certificata has b 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) To Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Affler Attending 5 Pending invasligation 1 Naturel 1 ☐ Yas 2 ☐ No actor: by the 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify) or A 4 T Homicide 24 hours Funeral Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) end menner as stated.

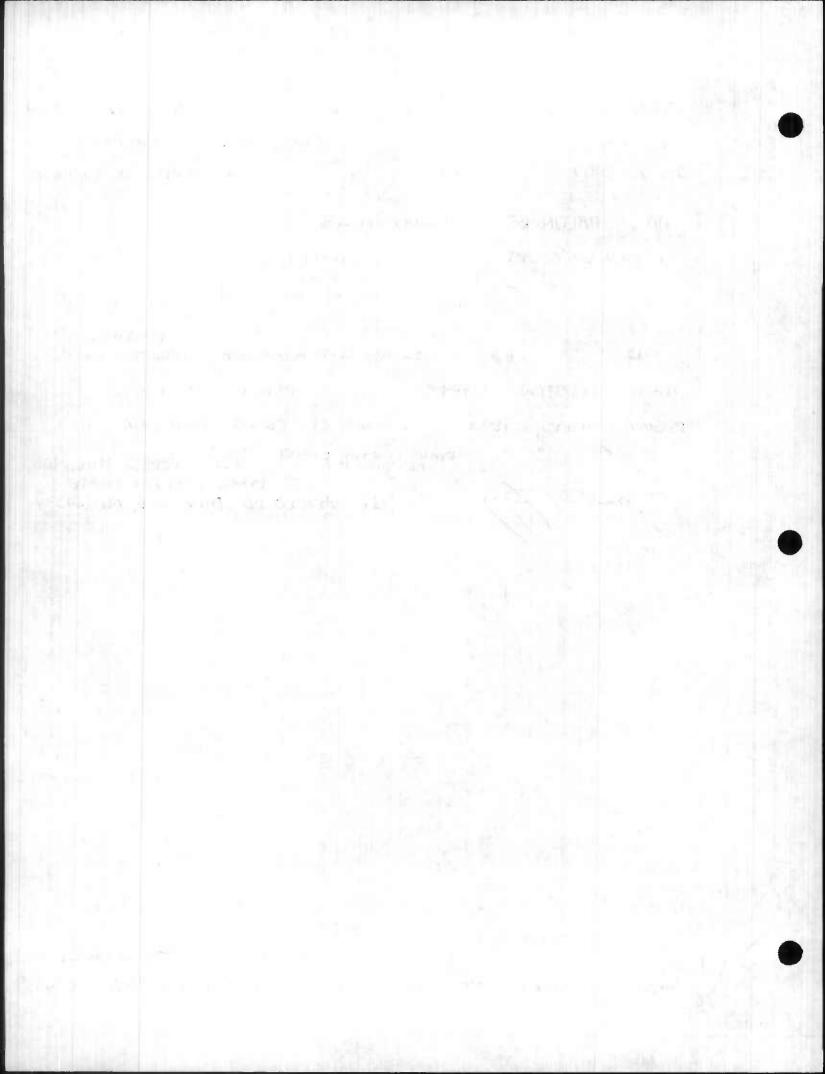
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) 29e. Certifier edical and manner steted. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cetti 0 44284 JAN 3,2001 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 5501 LOCH EAVEN BLYD STE 207 BAUTO, MD 21239 FRAIMAN MD. MARK 31. Date filed (Month, Day, Year) 32. Regisirar's Signatura State

DHMH 16 Rev 6/95

Registrar

ORIGINAL

across



**Physicia** /Medic Examin

**Funeral** Director

parmit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mantel Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Wedless Essen has the notified at page.

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

1	5	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 0 0 4 2 9 2 7												
	1. Decedent's Name (First, Middle, Last)								2. Date of Dea	th		Vana	3. Time	of Death
n -i	Thomas M. Thor	npson							Month Decemb		30.	Year 2000	12:	30 PM
al er							4b. City, To	wn, or Lo	or Location of Death 4c. County of Death					
	10600 Davis Ave. #A-2						N	oods	lstock Baltimore					
	5. Social Security Number 6. Sex 1	2 F 7. Ag	e (In yrs. last birt 75	75 Yrs. Isst birthday) If Under 1 Yas Months Day			If Under Hours	24 Hrs. Min.	8. Date of Birth July 8	th 9. Bit Mar		9. Births Mary	nace (Stell	e or Foreign
	Usual Residence of Decedent													
lips .	10a. State 10b. County		7, Town or Location 10d. Inside City Lin											
cto	Maryland Baltimor	W	Woodstock						101	as 2 No				
Dire	10e. Street and Number				10f. Zip Co									
8	10600 Davis Avenue	#-A-2			211	03								
by Funeral Director	11. Marital Status  12. Was Decedent Ever in Armed Forces?  1 Never Merried 2 Merried 1 Tyes 2 No It Yes, Giva Year or Dates:			H,	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yas 2 ☒ No Spacify:   Specify: W					ck, White,				
	3 ☐ Widowed 4 ☒ Divorced	Year or Dates:		Dest						4.01	Vind of D			
ete	15. Decedent's Education (Specify only highest grede completed)			(Give ki	nt's Usuel Occupation 16b. Kind of Business/Industry nd of work done during most of working 5 NOT use retired)									
duc	Elementery/Secondary (0-12)	5+)		ariner	-,		Boating			ng	ng			
o Be Completed	17. Fathar's Name (First, Middle, Last) Paul Thompson  18. Mother's Name (First, Middle, Meiden Sumame) Delia Nelson													
-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Straat end Number or Rural Route Number, City or Town, Stete, Zip Code)													
	Delia Thompson (daughter) 10600 Davis Ave. #A-2, Woodstock, MD. 21163													
	20e. Method of Disposition 1 M Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cematery, cremetory or other place) Maryland Veterans Cem.  20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State													
	21. Signature of Funeral Service Licenses   22. Name and Addrass of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD. 21122													
	23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of	ions that caused cause on each li	d the death Do r	not enter	r the mode of	f dyi	ng, such as	cardiac	or respiratory ar	rest,		1	Approxin Intervel I Onset ar	Between
	Immediate Cause (Final disease or condition Intra - Cere brat Hemorrhage													
ne	Due to (or as a consequence of):  b. Hypertensive Cardiovascular Disease													
Examine														
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying													
Physician/Medical	Cause (Disease or Injury that initiated events Due to (or as a consequence of):									1				
	d			_										
	Part II. Other significant conditions contrib	outing to death b	out not resulting in	tha und	derlying caus	se gi	ven in Part	l.	23b. Did t	obac	co uee co	ntribute t	o the cau	se of death?
_									101	/ee	2□ No	3 Pro	bably 4	Unknow
ompleted by									24a. Was perfor	med a		av co	railable pri empletion death?	

urs after death.

eral Director: After this certificate hes been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-trensit To the Hospital or Attending Physician: The lew requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, Be Medical Certification: To hin 24 hours Me Funeral

25. Wes case referred to medical 27. Menner of Death 1 Accident 3 Suicide 4 Homicide

1₽ Yes 2□ No

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Dey Year)

28b. Time of

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) at scene 28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifian

29c. Licansa number

29d. Data signed (Month, Dey, Year)

Chut is

OCME

December 31, 2000

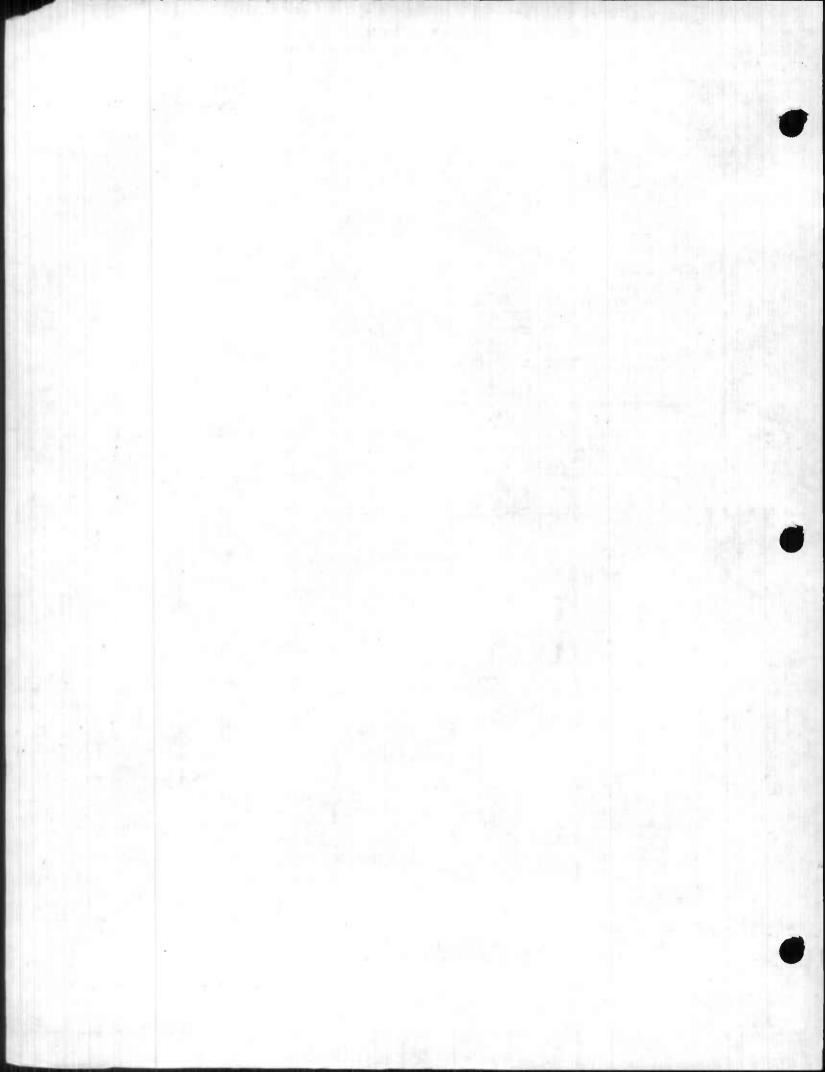
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lennis hutemo 31. Data filed (Month Day Year)

32. Registrar's Signatura

Penn Street, Baltimore, Maryland 21201 outs

State Registrar 111

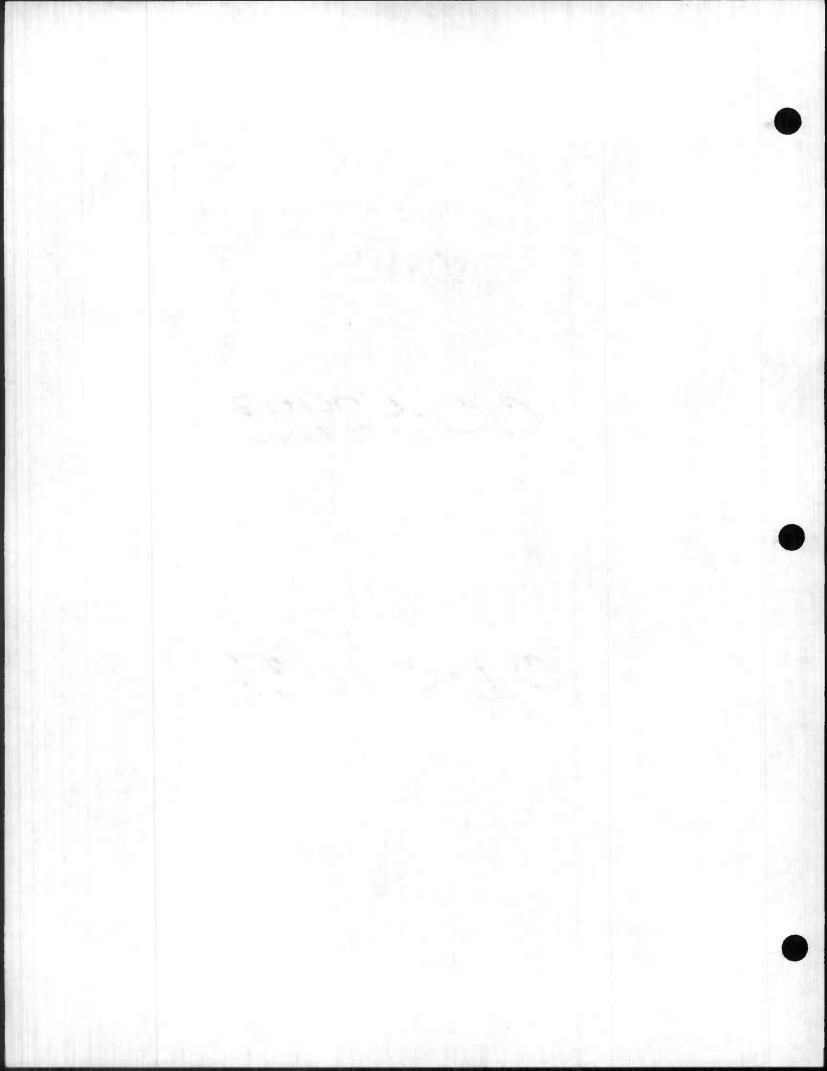


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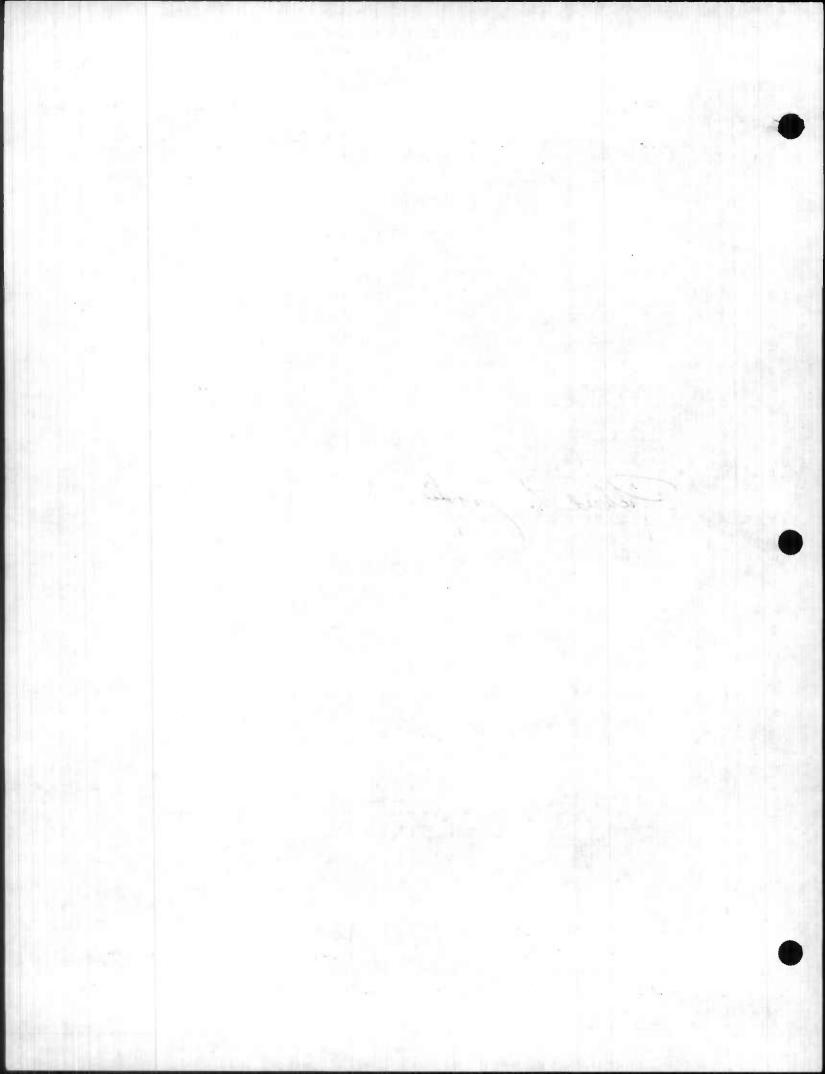


State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No.	42929									
DI ALLE		Date of Death Month Day	3. Tima of Death									
Physicia /Medica	IACP H ADAMA	December 27,	2000 5:30 PM									
Examine	45 City Tours or Locati	ion of Death 4c. County	of Death									
	VA Maryland Health Care System Perry Poi											
Funeral Director		Dale of Birth (Month, Day, Year) UNC 22, 1927	9. Birthplaca (Stata or Foreign Country) Pennsylvania									
1 1-	Usual Residence of Decedent  10a. Stata 10b. County 10c. City, Town or Location		10d. Inside City Limits									
Maryta 4 shor	Maryland Cecil Rising Sun		1 ☐ Yes 2 No									
with the Mary a or 28e-f ah be notified.	Maryland Cecil Rising Sun  10e. Street and Number 10f. Zip Coda	10g. Citizan of V	10g. Citizan of Whal Country?									
She o	136 Goss Lane 21911	USA										
1 19	11. Marital Status  12. Was Decedent Ever In U,S. Armed Forcas?  1 Nevar Married 2 Married  12. Was Decedent of Hispanic Origin? (Specify France of Married It Yas, specify Cuban, Mexican, Puarto Rici		a - American Indian,									
03(	* 3 ☐ Widowad 4 ☑ Divorced Yaar or Datas: WW II 1 ☐ Yas 2 ☑ No. Specify: Specify: W											
IAN TZ PA	15. Decedent's Education (Specify only highast grada completed)  16a. Decedant's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Bu	sinass/Industry									
PHYSICIAN Ind 21215-0 be lited within 72 ha ind Hygiene of other than "netur event, the Medical	Elementary/Secondery (0-12) College (1-4or 5+)	,,	2									
IVS		Harness First, Middle, Maiden Sumem										
Par Band			a)									
Tyle Tyle of Man	P Jacob Adams Suzanna   Suzanna    19a. Informent's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural R		State Zin Code)									
	Elizabeth Gwaltney/Daughter 187 N. Fieldcrest Dr.,											
			City or Town, Slata									
A A O	1 M Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify)  St. Columb Rille Cemetery 1-	2-01 Imperi	al DA									
VAME KNO  JACK ADA  Baltimore, emit Pages 1 is separament of He important: it hem my injury or othe ente.	21. Sporture of Poweral Sarvice Licensea 22. Nama and Addrass of Facility		ac, rn									
N P P P P P P P P P P P P P P P P P P P	R. T. Foard Funeral Home, P. A.											
	234 Part Enter the disease, or complications May caused the greath. Do not enter the mode of dying, such as cardiac or re	sing Sun, MU aspiratory arrast,	Approximata									
Physician	shock, or haart tailure. List only ona cause of each lina.	234 Part Enter the diseasa, or complications have used the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, Shock, or heart tailure. List only one cause of each line.  Approximate Interval Between Onset and Death										
/Medical	Immediata Causa (Final											
90 Examiner	resulting in deeth)  a. Cerebral Vascular Accident  Dua to (or as a consequence of):	disaasa or condition resulting in deeth)  Cerebral Vascular Accident  a. Cerebral Vascular Accident										
/			3 weeks									
58760, icate be axecuted physician and s the buriet-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b										
s axe surial-												
68760, rifficate be axing physician is as the burial	resulting in death) Last  Due to (or as a consequence of):											
5 0 8												
BOX death cert e attendin of for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
the de ached ached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use con	Did tobacco use contribute to the cause of death?									
C X 70		1 Yes 2 No 3 Probably 4 10 Un										
S S S .	p d	24a. Was an autopsy										
Tequ been shoul	ŏ	performed?	aveilabla prior to complation of causa									
Rec elaw has t	Completed	4 CT 14 - THT 14	of deeth?									
f Vital Royalden: The Last secutificate had director, page		1 Yas 2X No	1 Yas 2 No									
of Vita Physician: this certific	axeminar?	5 ☐ Rasidenca 6 ☐ Oth	er (Specify)									
Physic prints or this oral d	To injustion 2 de voulparion de 2007	d. Dascribe how injury occur										
ion oding R	1 Matural 5 Panding (Month, Dey Year) Injury Work? 2 Accident Invastigation M 1 Yas 2 No											
Atter dea	27. Menner of Deeth    Tablatural   5   Panding   2   Accident   3   Suicide   4   Homicida   4   Homicida   288. Data of Injury   288. Data of Injury   288. Tima of Injury   2	28f. Location (Street and Number or Rural Route Number, City or Town, Stata)										
O para	ouliding, etc. (Specify)											
Division C To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completaly filled in by the funeral	29a. Certifier  (Check only one)  12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
Within To the Comp	29b. Signatura and fitta of certifler 29d. Dala signed											
	D16608	Decem	ber 28, 2000									
10 1 1/10	30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)	Decem	207 2000									
12 + IVA	KAM KEN LEUNG, M.D., VA Maryland Health Care System, Pe	rry Point, ME	21902									
State	e 31. Date filed (Month, Day, Year) 32. Registrar's Signatura											
Registra	DEC 2 9 2000 Server B. Spalls											

DHMH 16 Rev 6/95

**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death **Physician** FRANCIS BEAN, SR. TAMES DECEMBER 27,2000 11:55 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CIVISTA MEDICAL CENTER CHARLES LAPLATA 7. Age (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Deys Hours 1DM 2□F Yrs. 218-16-3098 76 Director SEPT. 17, 1924 MARYLAND Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. tnside City Limits TY Yes 2 No Director MARYLAND CHARLES INDIAN HEAD 10f. Zip Coda 10g. Citizen of Whet Country? 10e. Street and Number ò 234 105 WOODLAND ROAD 20640 UNITED STATES Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 (2x/yes 2 □ No If Yas, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indien, Bleck, Whita, etc. r than "natural", or iten 1 □ Nevar Married 2 □ Merried 1 ☐ Yas 2 ☐ No Specify: Specify: by 3℃ Widowed 4 □ Divorced BLACK Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry il Hygiene. Elementery/Secondery (0-12) Collega (1-4or 5+) 7th TRUCK DRIVER FEDERAL GOVERNMENT 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 Mental JAMES FRANK BEAN MARY ROSE WHITE BEAN and 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) . Department of Health a important: if Hem 27 is eny injury or other traphre. JAMES F. BEAN, JR / SON 105 WOODLAND ROAD INDIAN HEAD, MARYLAND 20640 20b. Plece of Disposition (Neme of cematery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Removal from State ST. CHARLES CEMETERY 1/2/01 GLYMONT, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funerel Service Licensee J 22. Nama and Addrass of Fecility THORNTON FUNÉRAL HOME, P.A. DIA C. THORNTON JOHNSON MO0583 110 3439 LIVINGSTON ROAD INDIAN HEAD, MD 20640 23a. Pert1. Enter tha diseese, or complications that caused the daath. Do not anter tha mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onsat end Daath Physician tmmediate Ceuse (Final diseese or condition rasulting in daath) /Medical colon Retastatic Examiner Due to (or as a consequenca ot): Physician/Medical Examiner The law requires that the death certificate be asscuted and Sequentially tist conditions, if eny, leading to immediata cause. Enter Undarlying Cause (Diseasa or injury Due to (or as a consequence ot): Box 68760. that initiated events rasulting in death) Lest Due to (or es e consequança of): the USB AS P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tyss 2 No 3 Probably 4 Unknown à Records, 24b. Wera autopsy findings eveilable prior to completion of causa ot daeth? 24e. Wes en eutopsy performed? Completed page 1 Yes 25€No 1 ☐ Yes 2 ☐ No of Vital Physicien: Be 25. Wes case ratarred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No edicai Certification: To 28c. Injury at Work? 27. Menner of Death 28d. Dascribe how injury occurred Division or Attending t Neturet 2 Accident 5 Pending investigation after death. 1 ☐ Yas 2 ☐ No tha 3 Suicide 6 Could not be detarmined 28t. Location (Street end Number or Rurel Route Number, City or Town, State) 28a. Plece of tnjury - At home, tarm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel C To the Hospital Certifying Physician: To the best of my knowledga, deeth occurred et the time, date end plece, and due to the causa(s) and manner es stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, deta end place, and due to the cause(s) end menner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and titla of certifier 29c. License number Stutting 12-28-0 sheed D-31675 WHITE PLAINS MD. 30. Nama and address of person who completed cause of death (Item 23e) (Type, Print) WAHEED U. AKTHAR M.D. WHITE PLAINS MEDICAL CENTER P.O. BOX 1737

DHMH 16 Rev 6/95

State

Registrar

31. Dete tiled (Month, Dey, Year)

JAN 0 2 2001

32. Registrar's Signeture

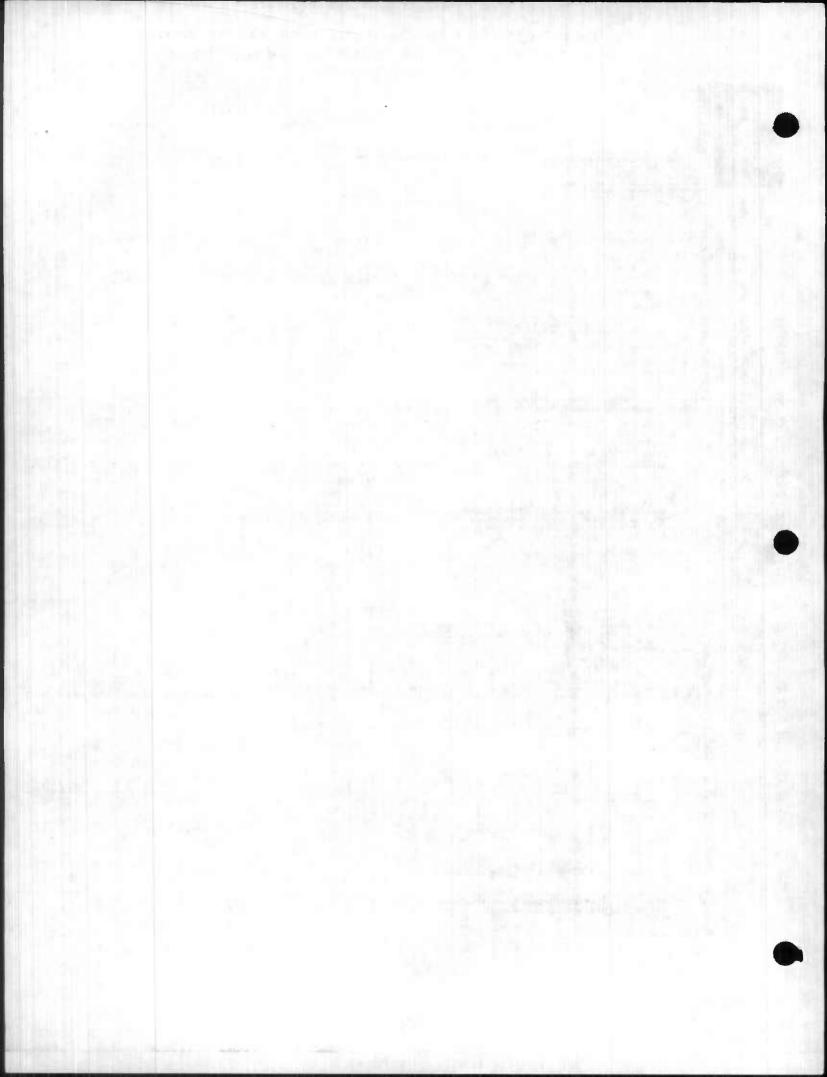
20695

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Rea No. 0 4 2 9 3

			Cer	tificate o	f Death		Reg. No.	42931			
Dhusisian	1. Decedent's Nama (First, Middla, Last	)	1			2. Dete of De	eth Dev	3. Tima of Death			
Physician /Medical	Kevan	E.	В	rowne,	Sr.	Decemb	per 23, 2	2000 0118			
Examiner	4e Facility Nama (If not institution, giva	street and number)				, or Location of Deat					
	Union Hospital				Elkt		Ceci				
Funeral Director	5. Social Security Number 6. Se 15 215-56-5364 Usuel Residence of Decedent	x 7. Aga (fn yrs 51	( last birthday) Yrs.	If Undar 1 Ya Months Day		Min. (Month, De	th ly. Year) ), 1949	9. Birthplace (State or Foreign Country) Maryland			
with the Maryland a or 28a-f show Lbe notified at Director	10a. Stata 10b. County 10c. City, Town or Location Elkton							10d. Inside City Limits 1 ☐ Yas 2 💆 No			
outh with the Maryla ne 23a or 28e+f show must be notified at seral Director	10e. Street and Number 153 Arbutus Street	et		10f. Zip Code 219			10g. Citizen of What Country? United States				
- 4 44 5	11. Meritel Stetus  1 Nevar Merried 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Dates:	r in U,S.  13. Wes Decedent of HispenIc Origin It Yas, specify Cuben, Mexican,  1 □ Yes 2 ☒ No Specify:			? (Specify Yes or No uerto Ricen, etc.)	- Amarican Indian, K, Whita, atc. White				
5-0 72 ho	15. Decedent's Edu (Specify only highast grad		16a. Deced	ient's Usual Occ	cupation	f working	16b. Kind of Businass/Industry				
Maryland 21215-0020  2 should be fited within 72 hours at its and Mental Hygiene. The marked other than "natural", or bearmaild event, the Medical Exam To Be Completed by F	Elementery/Secondary (0-12)	College (1-4or 5+)		oo Not use ret	na during most of ired) 'er	Working	Food Delivery				
nd and the second and	17. Father's Neme (First, Middla, Last)					Name (First, Middla		a)			
ylar Monta M	Charles Browne		ucht		Eliza	abeth Paul	У				
far 2 sho and but is me	19a. Intorment's Name/Ralationship (7)	rpe, Print)				or Rural Routa Numb					
CHNE	Kevan E. Browne,					, Elkton,					
Baltimore, emil. Pages 1 a appartment of Hei mportant: If Nem ny Injury or othe BISS.	20a. Mathod of Disposition  1  Burial 2  Cremetion 3  4  Donation 5  Other (Specify)	Removel from Stata	cematary, cran	sition (Nama of netory or other ; nen's Ce	olace)	Data 12/27/0	20c. Location - City or Town, State				
Baltim permit. Pa Department important: any injury ance.	4 Donation 5 Other (Specify) St. Stephen's Cemetery 12/27/00 Earleville, Maryland 21. Signature of Funaral Sarvice Licensee 22. Nama end Addrass of Facility Hicks Home for Funerals, P.A.										
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart tailure. List only one ceuse on each line.  Approximate 103 W. Stockton St., Elkton, MD 21921  Approximate 103 W. Stockton St., Elkton, MD 21921  Approximate 103 W. Stockton St., Elkton, MD 21921										
The second second	shock, or heart tailure. List only o	na ceusa on aach lina.	itii. Do not ent	ai tha moda oi t	lying, such as car	rolec or respiretory a	irasi,	Interval Between Onsat and Death			
Physician // // // // // // // // // // // // //	Immediata Causa (Final	Minutes									
Examiner	diseasa or condition rasulting in death)  Cerebral Hemorrhage  Due to (or as a consequence ot):										
D E		Cirrhosis of Liver Years									
68760, tificate be executed to physician and as the burial-transit	Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disaase or injury that initieted events	Dua to (or es a consequanca ot):  Alcoholism Years									
68760, ficate be an in the burial edical E	Cause (Disaase or injury that initieted events rasulting in daath) Last	C. Dua to (									
E 00 E		d.									
Box death cert death cert e attendin de for use				1	23h Did tohanno usa contributa to the source						
P.O. Box at the death certified by the attending eleached for use a Physician/M	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	ndarlying causa	givan in Part I.		23b. Did tobacco usa contributa to the cause of death?  1 XYss 2 No 3 Probably 4 Unknown				
* # 9 P	Smoker	114 201					158 20 140	0-110000) 4-011110WII			
requirements been should	Hypercholesterolemia 24a. Was an autopsy performed?							24b. Ware autopsy tindings eveilabla prior to complation of causa of death?			
The law The law page 2						10	Yas 210 No	1 ☐ Yas 2 ☐ No			
Vital I	25. Was case referred to medical axaminar?				26. Plece of	Deeth (Check only	one)				
- 5 E	1 Yas 2 No	Hospital: 1 ☐ Inpatiant 2 ☑	ER/Outpatier	nt 3D DOA	ing Homa 5□ Res	dance 6 Othe	ar (Specify)				
Vision of Attending Phyrideath. ector: After this by the funeral iffication: 1	27. Mannar ot Death  1 ②Natural 5 □ Panding 2 □ Accidant invastigation	28a. Date ot Injury (Month, Day Year)  28b. Time ot Injury Injury  28c. Injury at Work?  M 1 Yes 2 No					28d. Dascribe how injury occurred				
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide detarmined	28e. Plece of Injury - At I building, atc. (Spec		eet, tactory, offi	08		cation (Street and Number or Rural Routa Number, y or Town, Stata)				
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier  (Check only one)  1 **Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  2 **Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.										
To the within To the compl	29b. Signatura and title of certifiar	- 1	464	29c. Lice	29c. Licansa number 2			29d. Data signad (Month, Day, Year)			
	1 Loulp	4			0291		December 26, 2000				
10	30. Nema and addrass of person who co				Elkton	, MD 219:	21				
State	31 Date filed (Month, Day, Year)	32. Registrar's Sign		Pereer	DINCOIL	, 110 219	ar u5,				



Please Type or Print in Biack Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) Day Month Bauser **Physician** Lester 08 00 A December 22, 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 8. Data of Birth (Month, Day, Year)
MAR • 25, 19:10

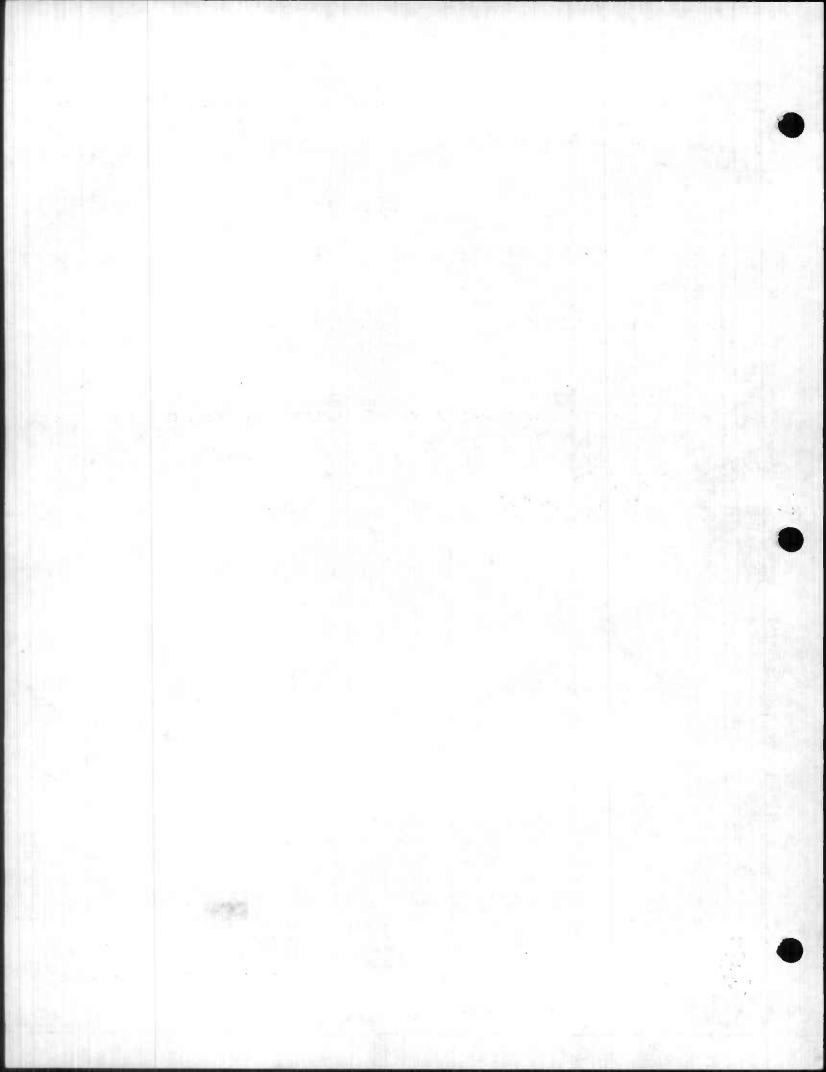
9. Birthpla Country
NEW If Under 1 Yaar If Under 24 Hrs. Birthplace (Steta or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days Hours 10XM 2□ F Months 90 096-03-2716 Director YORK Usual Rasidance of Decedant 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits must be notified at MD. MONTGOMERY ROCKVILLE 1 X Yas 2 □ No Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 9701- VEIRS DRIVE 20850 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 Yas No If Yas, Giva 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status Black. White, atc. 1 Nevar Marriad 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yas 2 ☐ No Specify: WHITE Specify þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) then Elementary/Secondary (0-12) Collega (1-4or 5+) MECHANICAL ENGINEER BULOVA WATCH CO. 18. Mothar's Nama (First, Middle, Maiden Sumama) 17 Fathar's Nama /First Middle Last) Be should be f and Mental ) LOUIS E. BAUSER BERTHA A. BAUSER MEYER is marked permit. Pages 1 and 2 sh Department of Health and Important: if them 27 is man any injury or 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Ralationship (Type, Print) JANET BAUSER BOYLES-DAUGHTER- 8827 THOMAS LEA TERR., GAITHERSBURG, MD. 20c. Location - City or Town, 370 886 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Ramoval from Stata PARKLAWN MEMORIAL CEM. - 12 / 27 - ROCKVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licenses 22. Nama and Address of Facility HYSONG CO., INC. 6510-16th ST., NW, WASH., DC r tha moda of dying, such as cardiac of raspiratory arrest, causad tha daath. Do not antar Approximata Intarval Batween Onset and Death 23a. Part1. Entar tha disaase, or co shock, or haart failura. List or **Physician** Immediata Causa (Final diseasa or condition rasulting In death) /Medical Pneumonia Examiner Due to (or as e consequance of): Physician/Medical Examiner attending physician and for use as the bunal-transit certificate be asscuted Sequentially list conditions, if any, laading to immadiata cause. Enter Undarfying Cause (Diseasa or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760. Dua to (or as a consequance of): 23b. Did tobacco use contributs to the causs of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Nonknown signed t p Olvision of Vital Records, 24b. Wara eutopsy findings available prior to complation of causa of death? 24a. Was an eutopsy performed? paga 2 should Completed peen The law r After this cartificate has 1 Yas 2 No 1 Yas 20 No spital or Attending Physician: mours after death, norrs after death, neral Director: After this carificat if filled in by the funeral director, p 25. Wes case referred to medical axaminar? Be 26. Plece of Deeth (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 1 12 Inpatiant 10 2 ER/Outpatient 3 DOA 27. Menner of Death 1 Denetural 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be detarmined 3 ☐ Suicida 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide To the Hospital
within 24 hours a
To the Funeral Completely filled Hospital edical 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, deta and place, end due to tha causa(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or invastigation, In my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted. (Check only one) 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian D53244 December 22, 2000

Registrar

31. Data filed (Month, Day, Year)
DEC 2 7 2000

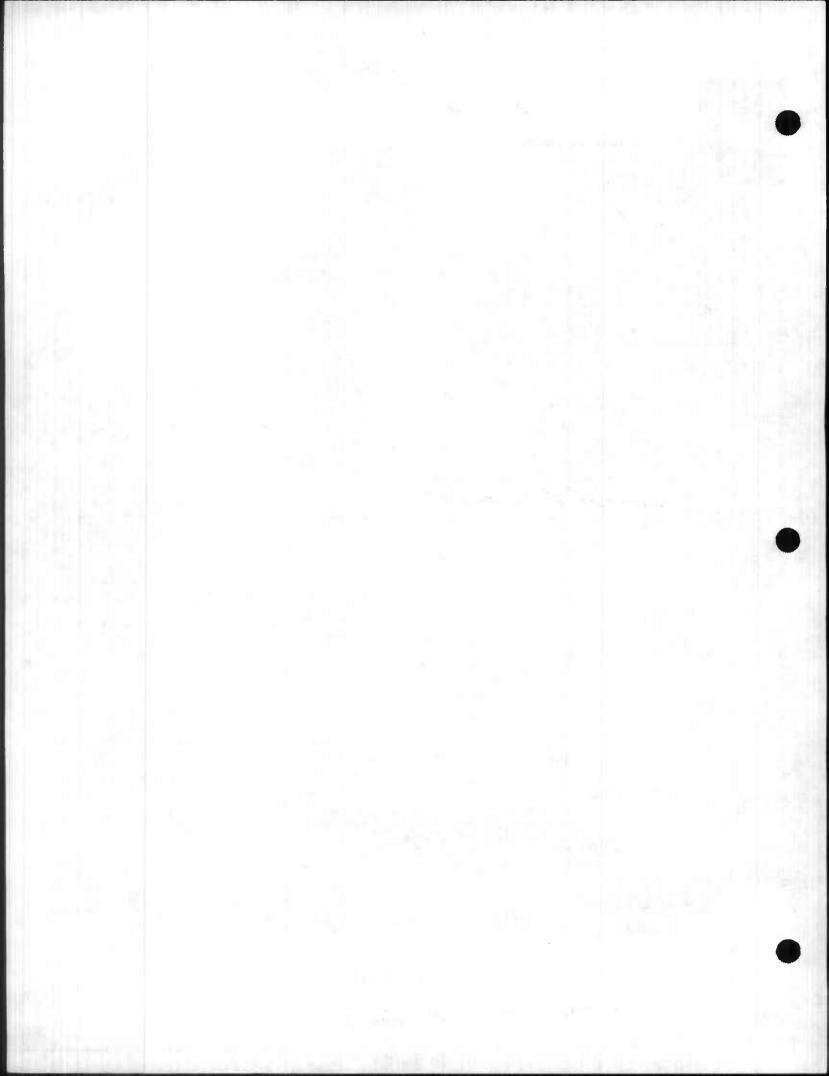
Katharine R. Lillie, MD 11140 Rockville Pike, PMB 348, Rockville, MD 20852 32. Registrar's Signatura

30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			Certificate of	Death	Reg	. No.	72700			
Physician	1. Decedent's Neme (First, Middle, La				2. Dete of Deeth Month	Dey Yee				
/Medical		Shirley Mozel	le Bugenhag	<u> </u>	Decembe					
Examiner	4e Fecility Name (If not institution, giv	e street end number)		4b. City, Town, or Lo	ocation of Deeth	4c. County of De	eth			
	Anne Arundel M	Medical Cente	r	Annapol	is	Anne A	rundel			
Funeral	5. Social Security Number 6. S		t birthdey) If Under 1 Yea Months Dey:		8. Dete of Birth (Month, Dey, Y	(ear) 9. B	irthplece (State or Foreign Country)			
Director	577-42-4158	□ M 20xF 65	Yrs.	110010	Feb. 2,	1935 i	exas			
70	Usual Residence of Decedent									
Maryland H show	10a. Stete 10b. County	10c. City,	Town or Location			10d. Inside City Limits				
the Maryla 28a-f eho nourse at	Md. Anne Ar	rundel A		1 ☐ Yes 2 ☒ No						
r 28a-f	10e. Street and Number		10f. Zip Code			10g. Citizen of Whef Country?				
th with 23a or at Dir	2705 Coxswain	Place	11	ISA						
firer death with the Ma r Herre 23a or 28a-fe fiver must be northed funeral Director	11. Mental Status	12. Wes Decedent Ever in U.S.	Wes Decedent Ever in U.S. 13. Wes Decedent of Hispanic Origin? (S				nerican Indien,			
Fun Her	1 Never Merried 2 Merried	Armed Forces?	If Yes, specify Cu	ban, Mexican, Puerto	Rican, etc.)	Bleck, White, etc.				
hours effer hursi', or he	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Detes:	1□ Yes 2⊠No	o Specify:		Specify: W	hite			
5-002( 72 hours e netural', o	15. Decedent's Ed		16a. Decedent's Usuel Occ	unation	16	h Kind of Busines	e/Industry			
1 21215-0 ed within 72 ho sygiene. wr than "neturn rt, the wed can Completed	(Specify only highest gre	(Give kind of work don life. DO NOT use retir	e during most of work	ing	16b. Kind of Business/Industry					
d within piene.	Elementery/Secondary (0-12)	Home	e							
C Harring	17 Eathara Nama /First Middle Last		1101110							
id be fill be out the control of the	17. Fether's Neme (First, Middle, Last)	Benjamin Russ	2011		ome (First, Middle, Maiden Surneme)					
aryland should be file and Mental Hy marked other umatic event,					tha Bra					
Maryland d 2 should be filt the and Mental th 7 is merked oth treumadc even To Be	19e. Informant's Name/Reletionship (	Type, Print)	19b. Meiling Address (Street							
2 2 2 2 2	Roger Bugenhag		2705 Coxsw	ain Plac	e, Anna	polis,	Md.21401			
Baltimore, semit. Peges 1 en separtment of Heal mportant: if Nem 2 my Injury or other MGB.	20a. Method of Disposition	CONT	ce of Disposition (Name of netery, cremetory or other p	(ece)	1 _	c. Location - City	or Town, Stete			
Pege ent c nt: If	1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif	Hemovel from Stele	copolitan C	,	2-27-00	Alexand	ria, VA.			
Baltim permit. Per Department Important: any Injury once.	21. Signature of Fungetal Service Licer		22. Name and Add	ress of Facility						
Ban permi	11.11.	16-14		B	eall Fu					
	1241	2-9010		W. Crain						
3	23a. Pert1. Enter the disease, or com shock, or heart tailure. List only	plicetions that caused the deeth. one cause on each line.	Do not enter the mode of d	ying, such as cardiac	or respiretory erres	₹,	Approximete Interval Between			
Physician	Onset end Death									
/Medical	Immediate Cause (Finel disease or condition	Cardo	, Kulmono	en tto	eir					
Examiner	resulting in death)  Due to (or es e consequenca of):									
executed n and iel-trensit		Chroni	c Obstaces	live fu	Donona	er DI	casc			
60, be executed ician and buriel-trensit	Sequentially list conditions  Due to (or es e consequence of):									
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IS, P.O. BOY es that the deeth or igned by the ettend be detached for us by Physician	Part II. Other significant conditions of	ontributing to death but not resulti	23b. Did tob	23b. Did tobacco use contribute to the cause of death?						
Ph dby			100	1 No 3 Probably 4 Unknown						
b d b d				Wes en eutopsy performed? 24b. Were autopsy eveilable prior						
cords, requires been sign should be										
Dis S S S S S S S S S S S S S S S S S S S							completion of cause of death?			
The lew ste hes page 2					1 ☐ Yes	210 No	1 ☐ Yes 2 ☐ No			
Vital I	25. Wes case referred to medical			26 Pince of Post						
Of Vital Physician: Tr Physician: Tr ithis certificate ral director, pa	examiner?	Hospitel:	1. 0	ther:	h (Check only one)					
五 章 章	1 Yes 2 No		VOutpatieni 3DOOA	4 LI Nursing Ho	Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred					
ding h. After funer	1 DNaturel 5 □ Pending	(Month, Dey Year)	Injury W	ork? □ Yes 2 □ No	200. Describe non	injury occurred				
Division of tall or Attending P is after death. el Director: After t led in by the funers Certification:	2 Accident investigation									
Division or Attending after death. Director: After Jin by the fune ertification	3 Suicide 4 Homicide  3 Suicide 4 Homicide  3 Suicide 5 Could not be determined  28e. Plece of Injury - Al home, term, streel, fectory, office building, etc. (Specify)  28f. Location (Street end Number or Rural Route Number, City or Town, Stete)									
Ce de la co			TISS DIE							
Hospital Hospital Hospital Hospital Hospital Hospital Hospital Hospital Hospital	29e. Certifier  (Check only  (C									
\$ E \$ 8 0										
To the composition of the compos	29b. Signature and title of certifier	1	29d. Date signed (Month, Day, Year)							
	1 Other	1	12/26/00 MD 21401							
(11)	30. Name and address of person who	completed cause of death /Item 2	3a) (Type Print)			/				
(10)	2003 Medical	Parhwzas Su	et-100 An	INAPOUS,	MD 21	401				
		2. Registrar's Signetur		/						
, State	31. Dete filed (Month, Pay, Year)	Terres Signetul	4							

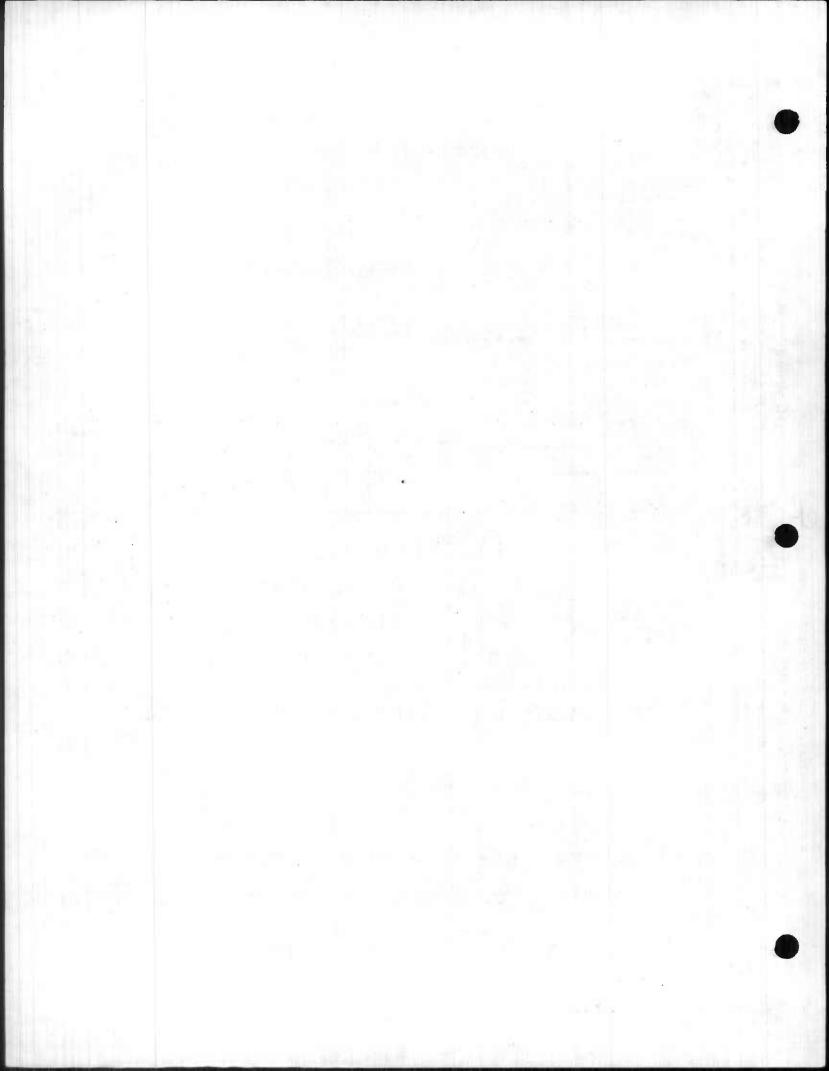


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State of Maryland / Department of Health and Mental Hygiene

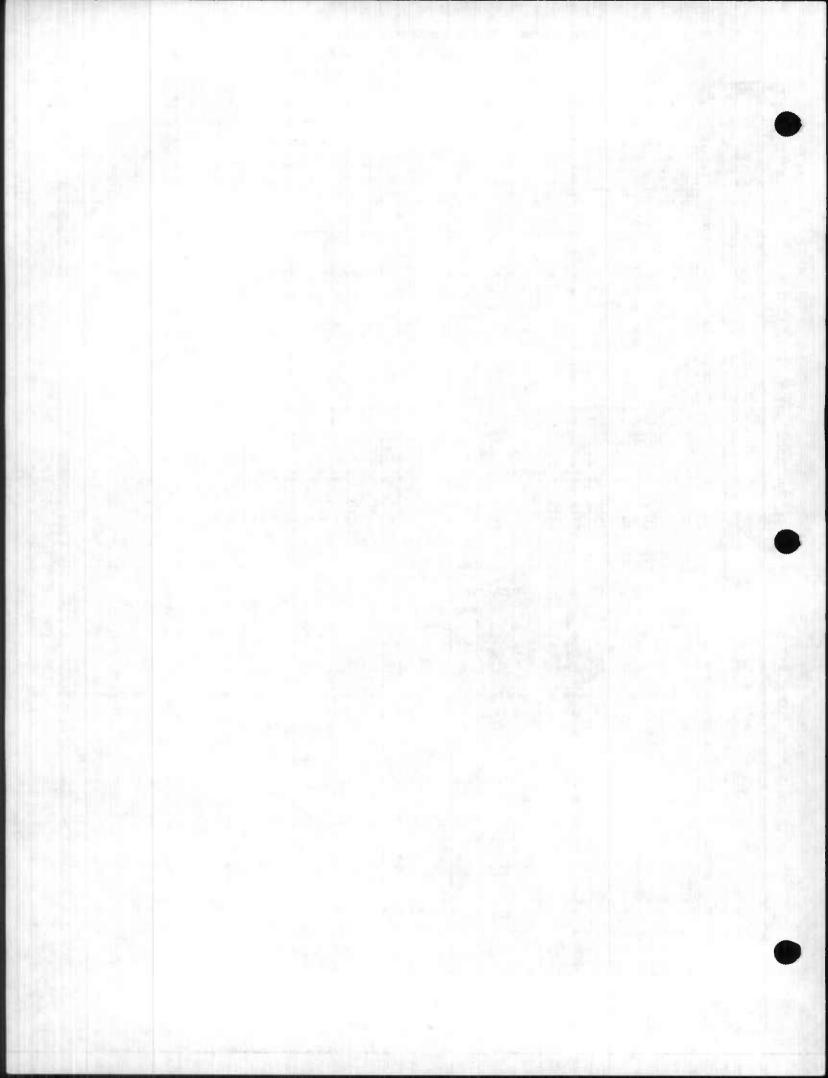
Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Nannie Louise Crosby Blakeney December 17, 2000 3:48 A.M. /Medical 4a Fecility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days 1□ M 2X F 66 Yes Director 579-46-7749 May 26, 1934 South Carolina Usual Residence of Decedent the Maryland 10s. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits re 23a or 28a-f ahow XYas 2 No Director District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 1 Neme 23a 20012 Untied States Funeral 7114 - 7th Street, N. W. deeth 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian Black, Whita, atc. pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mentel Hyglene. Important: If Item 27 is marked other than "natural", or the any Injury or other traumatic event, the Medical Examina 1 Yas ZX No If Yes, Give Year or Datas: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yas ZNO Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working tita. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. General Services Elementary/Secondary (0-12) College (1-4or 5+) Administration 12th grade Accounting Clerk 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Bevin Mary Lockhart Crosby 0 19a. Informant's Name/Relationship (Type, Print) Lee Blakeney, Jr. (husband) Avery Lydell Blakeney (son) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 7114 - 7th Street, N.W.; Washington, D.C. 20012 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 X Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery/Dec. 22, 2000 Washington, D.C. 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. PRO 20011 23a. Part<sup>1</sup>. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final mir disease or condition resulting in death) Examiner Examiner LOUS or Attending Physician: The law requires that the death certificate be axecuted physician and the burial-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 Division of VItal Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) attending p )endenc signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 Ao 3 Probably 4 Unknown Completed by 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? has 2 D No 1 Yas 1 Yas 2 No cartificata the funeral director, 25. Was cese referred to medicat axaminer? Be 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ XDOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Medical Certification: To 1 Yas 2 No this 28c. Injury at Work? 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of After 1 (XNatural 5 Pending investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 Accident 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifie 29c. License number 29d. Data signed (Month, Day, Year) 0 December 2000 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Shailesh Sheth, M.D.; 1221 Mercantile Lane; Largo, Maryland 32. Registrar's Signatura 31. Data filed (Month, Day, Year) DEC 28 2000 State Registrar



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	Decedent's Name (First, Middle, Last,		/ Department of I	2. Date of C	Reg. No. 0 0	2935 3. Time of Death	
Physician /Medical	Bert Charles,	Jr.		Decembe			
Examiner	4a Facility Name (If not institution, give Union Hospital	street and number)		4b. City, Town, or Location of Dec E1kton	Cecil		
Funeral Director	5. Social Security Number 224-60-8708 6. Set	7. Age (In yrs. last	birthday) If Under 1 Year Months Days	Hours Min 1 (Month, I	Birth 9. Birth Con. 9, 1945 Vir	place (State or Foreign intry) ginia	
death with the Maryland me 23a or 28a-f show meral be notified at	Usual Residence of Decedent  10a. State 10b. County Maryland Cecil		own or Location th East			10d. Inside City Limits 1 ☐ Yes 2/□No	
23a or 2	10e. Street and Number 9 Cedar Alley		10f. Zip Code 21901		10g. Citizen of What Country? U • S • A •		
- P 2 2 1	3 ☐ Widowed 430 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	13. Was Decedent of if Yes, specify Cub  1 □ Yes 2 No	Hispanic Origin? (Specify Yes or I van, Mexican, Puerlo Rican, etc.) Specify:	No- 14. Race - Amer Black, White Specify: Wh	, etc.	
1215-	15. Decedent's Edu (Specify only highest grad	College (1-4or 5+)	6a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Chool Bus N	during most of working od)	16b. Kind of Business/I Board of Education		
yland 212 ould be filed withi Mental Hygiene.  arked other than atic event, the M	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  18. Mother's Name (First, Middle, Maiden Sumame)  18. Mother's Name (First, Middle, Last)						
ges 1 and 2 should that I should the Health and Mer if them 27 is marke or other traumatic	19a. Intormant's Name/Relationship (Ty Dorothy Chambers			tand Number or Rural Route Num 1ey North Ea			
Baltimore, Noemit. Pages t and: Department of Health moortant: It item 27: any injury or other 27: and injury or other 27:	20a. Method of Disposition  1℃ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	emoval from State	e of Disposition (Name of etery, crematory or other pla per Cemeter		20c. Location - City or T Paynesvill		
Baltimo	21. Signature of Funerat Service Licens Edward Al.	McKown		ess of Facility Gee Fundain St. Elkt		921	
Certificate be executed noting physician and use as the burial-transit use as the burial-transit company.	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	s a consequence of):  O N s a consequence of):			Onset and Death	
	Part II. Other significant conditions cor	atributing to death but not resulting	ng in the underlying cause g	iven in Part I. 23b. D	Id tobacco uss contribute	to the causs of death?	
	S/P GI B	un)		1	robably 40 Unknown		
Vital Records, Palcian: The lew requires that certificate has been signed brector, page 2 should be detailed by P. S. S. S. S. S. S. S. S. S. S. S. S. S.	H1570R4 0	F CUA		24a. W	rformed?	Were autopsy tindings available prior to completion of cause of death?	
Vital Re- istien: The lever certificate hes rector, page 2		OF ATTRIAL T	FIBRILLAT			1 ☐ Yes 2 ☐ No	
Sing Physical distribution: Te	1 ☐ Yes . 2 ☐ No	dospital: 1 Inpatient 2 ER 28a. Date of Injury (Month, Day Year) 28	Bb. Time of Injury 28c. Injury	26. Place of Death (Check onither: 4 Nursing Home 5 Reiny at 28d. Describers: 1 No.		sity)	
Defe i	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	281. Location City or	n (Street end Number or Ru Town, State)	ral Route Number,	
We Hospital No. 24 hours No. Funeral pletely filled				ime, date and place, and due to the opinion, death occurred at the time			
To the within To the comple		0	20	se number 8 20	29d. Date signed (Mont)	m	
) State	30. Name and address of person who or 23 31. Date filed (Month, Day, Year)	empleted cause of death (Item 23)  (TST MAT)  32. Registrar's Signature	3a) (Type, Print)  St. EUC)  e	וד מון מח	1921, Josie	r Nisnisan, M	
Registrar	JAN 0 2 2001	herva 1	4 look	,			



Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #31.PGC 12-28-2000 cr 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) December 23, 2000 **Physician** 16:55 Odessa A. Covington /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital Center If Undar 24 Hrs 8. Data of Birth (Month, Day, ) ADILL 24, 7. Aga (In yrs. last birthday) If Under 1 Yaar 9. Birthplaca (Stata or Foraign 5. Social Security Number 6. Sex **Funeral** Hours 1 M 200F Months Days North Carolina 85 578-22-4980 Director Usual Rasidance of Decedant 10d. Inside City Limits 10a Stata 10h County 10c. City, Town or Location Nas 2□No Fort Washington Directo Maryland Prince George's 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20744 U.S.A. 12704 Gable Court Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ②No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Bace - Amarican Indian. 11. Marital Status 1 Nevar Marriad 2 Married Black 1 Yas 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementery/Secondery (0-12) Collega (1-4or 5+) 8th grade Housekeeper Domestic 18. Mothar's Nama (First, Middla, Meiden Sumama) 17. Fathar's Nama (First, Middla, Last) if Heelth and Mental Grady Edward Lowery Lottie L . Freeman 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 12703 Gable Court Fort Washington, Maryland 20744 Mr. Grady E. Covington (Son) 20b. Place of Disposition (Nama of cematary cramatory or other place)
Mount Olivet Cemetery Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Bunal 2 Cramation 3 Ramoval from Stata
4 Donation 5 Other (Specify) 12/29/2000 Washington, D.C. 22. Name and Addrass of Facility
Rollins Funeral Home, Inc. 21. Signature of Funarel Sarvice Licensee 4339 Hunt Place, N.E. Washington, D.C. 23a Party Enter the sugaran or complications that cousad the death. Do not antar the mode of dying, such as cerdiac or respiratory arrast, about or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Ventricular & Grillation Examiner Physician/Medical Examiner attending physicien and for use as the buriel-transit certificate be executed Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Diseasa or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Ware eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? or ington, Odessa page 2 8 200 No 1 ☐ Yas 21 No 1 Yas After this certificata Physician: 8 25. Wes cesa refarred to medical 26. Placa of Deeth (Check only one) Hospital: Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 1 Yas 2 No 1-Inpatient 2 ER/Outpatient 3 DOA 27. Mennar of Death 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 5 Panding invastigation 1 X Natural 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicida 6 Could not be detarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funerel C edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and mannar es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and mannar stated. 29a. Cartifiar 29b. Signatura and title of certifiar 29d. Data signed (Month, Day, Year) 29c. Licansa number December 23, 2000 almes

**DHMH 16 Rev 6/95** 

State Registrar

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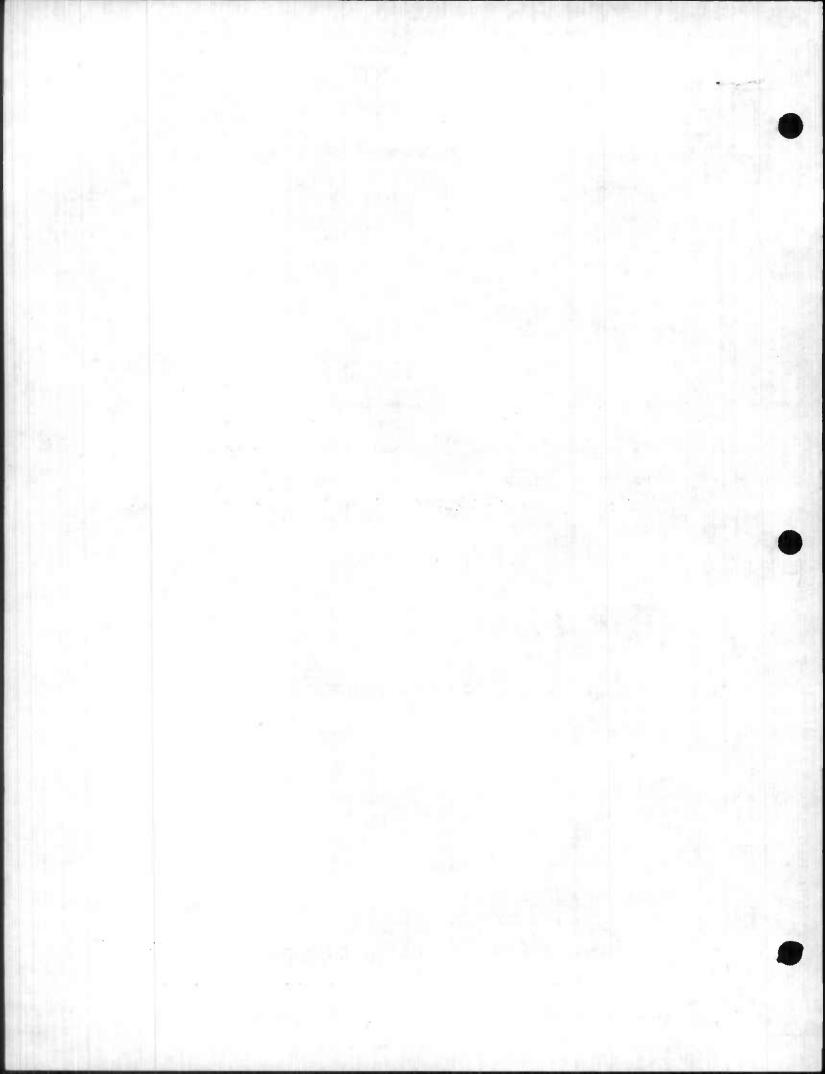
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oth, Day, Year)
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31. Data filed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
Richard Palmer, M.D. 4605 Martin Luther King, Jr. Ave.S.E. Washington, D.C. 20032



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedani's Nama (First, Middla, Last) 2. Data of Death Vaar Month **Physician** Dec 25, 8:00PM Linton Ralph 2000 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 18003 Claggett Landing Road Upper Marlboro Prince George's If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) 5. Sociel Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Days 10M 20F Months Yrs 245 16 9504 91 Director Nov 19, 1909 North Carolina Usual Residence of Decedent 10a Stata 10c. City, Town or Location 10b. County 10d. insida City Limits 1 ☐ Yas 2 ☐ No Directo Maryland Prince George's Upper Marlboro 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? man be r 18003 Claggett Landing Road 20774 United States Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 No If Yas, Giva 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Nevar Married XX Married b Baltimore, Maryland 21215-0036 1 ☐ Yas 2 ☐X Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 'netural' Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than the M Elementary/Secondery (0-12) Collega (1-4or 5+) Hygiene Clerk State of Maryland 12 parmit. Pages 1 and 2 should be file. Depertment of Health and Mental Hot important if filem 27 is meet any injury or other any injury or other. 18. Mothar's Nama (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Be Mollie M. Warren Linton K. Case 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 20774 Frances H. Case (WIFE) 18003 Claggett Landing Road, Upper Marlboro, MD 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Dec 29, 2000 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Gardens Davidsonville, Maryland 22. Nama and Addrass of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Lice Alexandria Ferry Rd, Clinton, Maryland 20735 aus ( 2.4 Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical STROKE Minutes Examiner Dua to (or as a consequence of): Examiner attending physician and for use as the burial-transit the death certificate be executed Sequantially list conditions, if any, leeding to immadiata cause. Enter Undartying Cause (Disaase or injury that initiated avants rasulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t heart failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Congestive Records. þ 24b. Wara autopsy findings availabla prior to completion of causa of deeth? 24a. Was an autopsy parformed? Completed ATRIAL FIBRILLATION has is certificate har 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vitai Physician: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home XXX esidenca 8 Othar (Specify) To 1 Yes 2 No this 27. Manner of Death 1 Netural 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? After Attending 5 Panding Invastigation death. 1 ☐ Yas 2 ☐ No Director: / 2 Accidant 6 Could not be detarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 4 ☐ Homicide ò To the Hospital o within 24 hours af To the Funeral Di completely filled is 1 Certifying Physician: To the best of my knowledge, daath occurred et tha tima, data and place, end due to the causa(s) end mannar as stated.

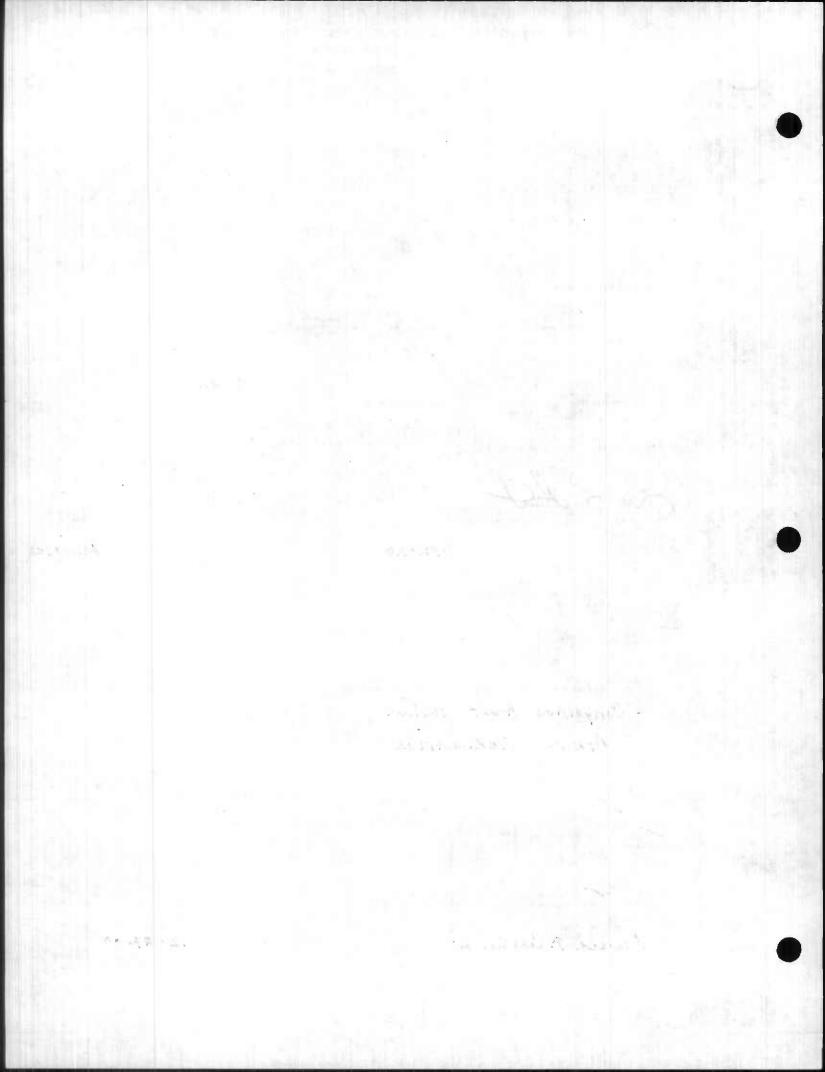
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and due to the cause(s) and mannar stated. edical (Check only one) 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) Edward 1. allen W 12 - 27.00 30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print) Edward Cullen, MD 4333 Old Branch Ave, Marlow Heights, MD 20748 31. Dala filed (Month, Day, Year) 32. Registrar's Signature

Registrar **DHMH 16 Rev 6/95** 

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ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth **Physician** December 23, 2000 9:35 PM BEATRICE CLORY IRMA /Medical 4b. City, Town, or Location of Death 4a Fscility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Montgomery Silver Spring Fox Chase Rehab & Nursing Ctr. 7. Age (In yrs. last birthday) If Undar 1 Yaer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 9. Birthplece (Si Country). June 27,1908 Virginia 5. Social Security Number 6. Sex 9. Birthplece (State or Foreign **Funeral** 1□M 2፟MF Months Deys Hours Director 578-92-0168 Usual Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f shot traumetic event, the Medical Examiner must be notified at 1 Yas 2 No Directo Washington N/A D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 20011 1418 Taylor Street N.W. Funeral 12. Wes Decedent Ever in U,S. Armed Forcas?

1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indien, 11. Maritel Stetus Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried **Black** Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: by 3 ₩idowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A Housewife 12th 18. Mother's Nema (First, Middle, Meiden Sumame) 17. Fethar's Nama (First, Middle, Last) should be h and Mental I Lennie Mickens Robert Lewis Thompson 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code 19a. Informent's Neme/Reletionship (Type, Print) permit. Pages 1 and 2 at Department of Health and Important: it flees 27 is in any injury or other traum once. 1386 Rittenhouse St., N.W. Washington DC 20011 Robert Alexander Clorey-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete Lincoln Memorial Cemetery 12-29 Suitland, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility eral Home, Inc. 4217 9th Street N.W. Washington DC 20011 23a. Part. Enter the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart feitura. List only ona cause on each line. Approximate fntervel Between Onset end Deeth Physician Immediate Cause (Final disaasa or condition resulting in death) /Medical siva ter Examiner Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran-Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Physician/Medical Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 100 1 Yes 2 No 3 Probably 4 Unknown signed by exchrovascular accident p 24b. Wara autopsy findings evailable prior to completion of causa of death? 24e. Was an autopsy performed? Completed Diabreter Mellitas. page 2 s 108 is certificate h 2 No 1 Yes 2 No 1 Yes Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No this funeral 27. Menner of Deeth

1 Naturel
2 Accident 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? Certification: After 5 Pending investigation after death.
I Director: After din by the fundament 1 TYes 2 □ No 6 Could not be detarmined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicida

Division of Vital Records, P.O. Box 68760, or Attending P

To the Hospital o within 24 hours aff To the Funeral DI completely filled in

State Registrar

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29e. Certifian (Check only one)

29c. Licansa number 10054566

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, daeth occurred et the tima, date and piace, and dua to the cause(s) end menner steted.

29d. Data signed (Month, Dey, Year)

30. Nama and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

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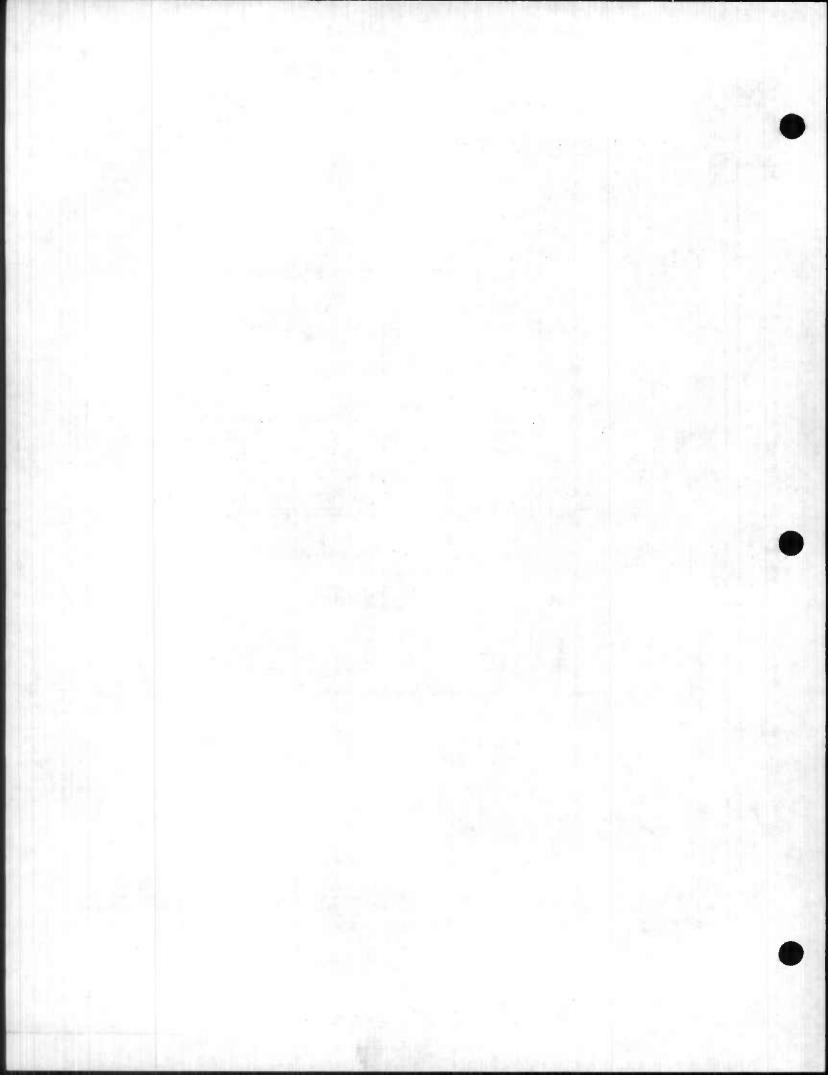
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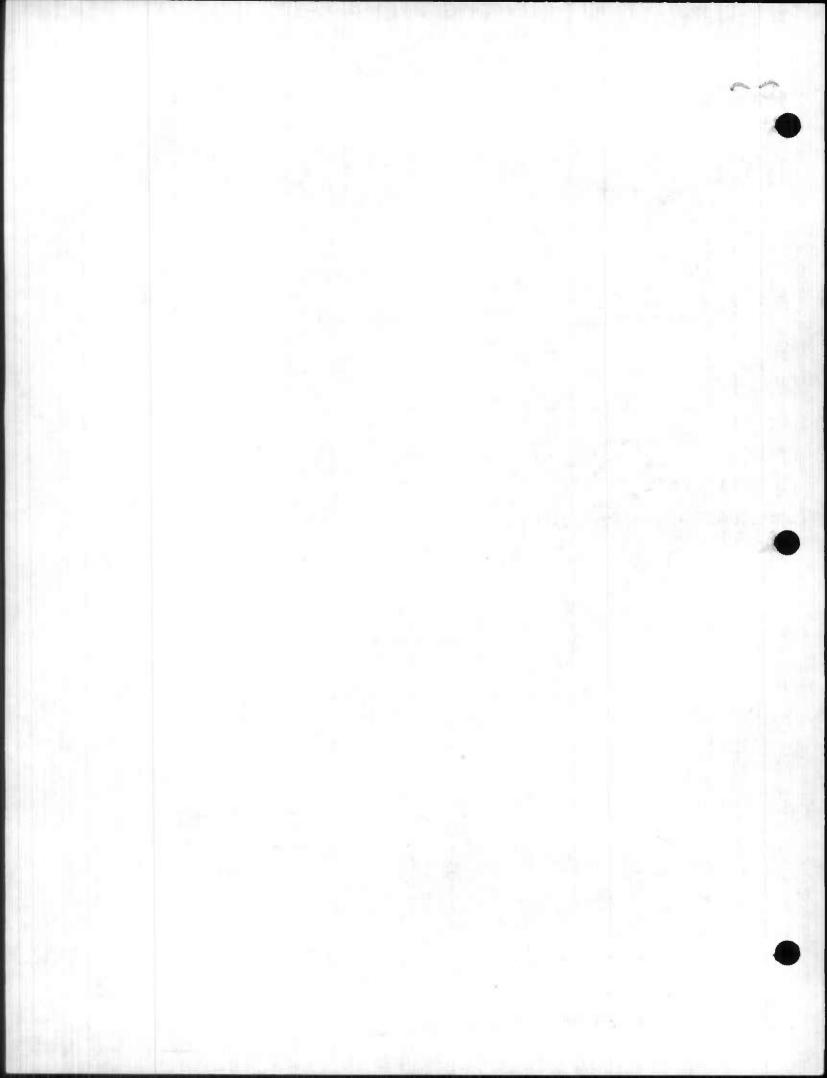
32 Registrer's Signatura

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Amend # 28	c. Per Phys.PGC 1		ryland / Depa $_{ m r}$ $Ce_{ m c}$	artment of t rtificate of		Mental Hy	rgiene Reg. No. 00	429	39
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S-00	15. Decedent's		16e. Dece	dant's Usual Occu	pation	de in a	16b. Kind of Bu	usiness/Industry	
Maryland 21215-0020 d 2 should be tiled within 72 hours at mortal hygens. The marked other than "natural", or traumatic event, the Medical Exam. To Be Completed by 8	(Specify only highest ( Elemantary/Secondery (0-12)	College (1-4or 5	+) life.	DO NOT use retire	during most of world)	rking	Virginia	Dublia	Cahaal
D Branch	17. Father's Name (First, Middle, La	5+ st)	Tea	cher	18. Mother's Nar	ma (First, Middle	Virginia , Maiden Sumem		SCHOOL
land ld be il cerved of sever	Andrew F. E. S					ret Bel			
Stout Many	19a. Informant's Name/Ralationship	(Type, Print)	19b. Maili	ng Address (Stree	t and Number or Ru			State, Zip Code)	
E 10 M A	Donald G. Croft	- Son	5216	Easton D	rive, Spr	ingfiel	.d, VA 2	22151	
altimore, mil. Pages t.a. partment of Hea portent: if Hean. y Injury or othe	20a. Mathod of Disposition 1 Durial 2 Ocramation 3	Demousi from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ice)	Data	20c. Location -	City or Town, Sta	ite
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Physician /Medical Examiner	Immediate Causa (Final disaasa or condition resulting in death)	LIU		RCING					mor Hs
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8760, rate be executed hysician and the burial-transit dical Examiner	Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or injury	169.45	Due to (or es a conse	quance of):					
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Hospi 24 hour Funer Mely fill		Phyelclan: To tha best of aminer: On tha basis of and mannar sta	axamination and/or in						ıuse(s)
To the comple	29b. Signature and title of certifier	^		29c. Lican	sa number		29d. Data signe	d (Month, Day, Y	ear)
(	Km	MI)		120	0391		DECEMBE	R23,2	000
(13)	30. Name and address of person when the DR T Kelm	o complated causa of do	eath (Item 23a) (Type,	\$ Print)	MIKHEL	41/16	MD		
State	31. Dete filed (Month, Day, Year)		ar's Signatura						
Registrar DHMH 16 Rsv 6/95	DEC 2 6 200	Seken	19.	Sports	_				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 22,2000 **Physician** 3:30pm JOHN C. CHAMBERS, JR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner 14009 TOLLISON ROAD BOWIE PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. May 22, 195 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** 1₩ 2□ F Months 152 50 6475 Yrs. 44 New Jersey **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Md. Prince Georges Bowie 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be or 14009 Tollison Rd. 20720 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Datas: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 8 1 Yes 2 No Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Al Hygiene. Elamentary/Secondary (0-12) College (1-4or 5+) Attorney Lawyer permit. Pages 1 and 2 should be file Department of Hestin and Mental Hyg Important if Nem 27 is marked other any Injury or other traumented other 9069. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) John C. Chambers, Sr. Naomi McGriff 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Georgette Chambers/ spouse same as 10e 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from Stata METROPOLITAN CREMATORY DEC. 24,2000 Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Rd., Bowie, Md. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in daath) /Medical DESMOPLASTIC CANCER OF THE TESTIS MONTHS Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es a consequence of): certificate be execu 68760 that initiated events resulting in death) Lest Due to (or as a consequence of) Box 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I. signed by 1 Yee 2 Sto 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 1□ Yes 2□No 1 ☐ Yes 2 ☐ No Division of Vitai I or Attending Physician: after death. Be 25. Was case referred to medicat 26. Plece of Deeth (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To this 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Invastigation 1 Natural 1 Yes 2 No 2 Accident Director: 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours at To the Funeral Di completely filled in 1 Certifying Phyelcien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certi 29c. License number 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

State

Registrar

31. Date filed (Month,

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32 Registrar's Signature

JOHNS HOPKINS HOSPITAL, BALTINORE.

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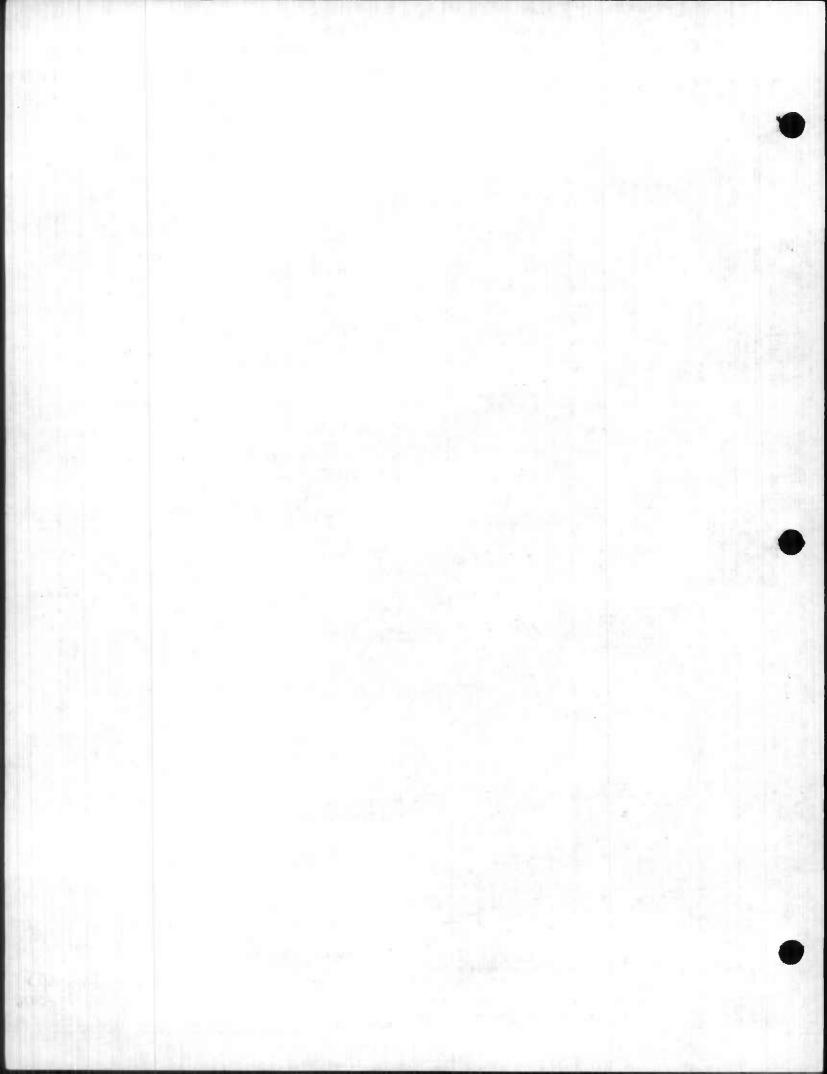
### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dete of Death le Cember **Physician** 4c. County of Death Clarence E. Cooper /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Doctors Community Hospital Prince Georges Lanham | H Under 1 Yeer | H Under 24 Hrs. | 8. Date of Birth (Month. Day. Year) | Hours | Min. | April 4, 1930 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** M 20 F Months 578-34-6660 70 Washington, DC Director Usual Residence of Deceden 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Prince Georges Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20737 6212 Carters Lane U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Edward 1 Yes 2 No Specify: white Specify: þ 3 Widowed 4 Divorced 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Cotlega (1-4or 5+) Printer Graphics 18. Mother's Nama (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) 器 Wilson Irving Cooper Carmel C. Randolph 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Item 27 I Virginia L. Cooper / wife 6212 Carters Lane Riverdale, MD 20737 20b. Place of Disposition (Neme of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 X Burial 2 Cremetion 3 Removal from State Ft. Lincoln Cemetery December 29,2000 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home Signature of Funerel Service License 3401 Bladensburg Rd. Brentwood, MD 20722 600 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each lina. Approximata Interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition rasulting in death) /Medical Examiner Sequentially list condition if any, leading to immedi-cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760, Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco ues contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Wara sutopsy findings evailable prior to Completed completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 88 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) OF 1 Copatient 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27, Mannar of Death Naturel 2 Accident 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be datamined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide b 15 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, end dua to the cause(s) end mannar as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at tha time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier edical (Check only one) To the To the 29b. Signature and file of certified 29c. License number 29d. Deta signed (Month, Dey, Year) 12-24-200 MD D34122 Name and address of parson who completed cause of death (Item 23a) (Type, Print)

Registrar

Tate filed (Month, Dey, Year) DEC 28 2000 32. Registrar's Signature

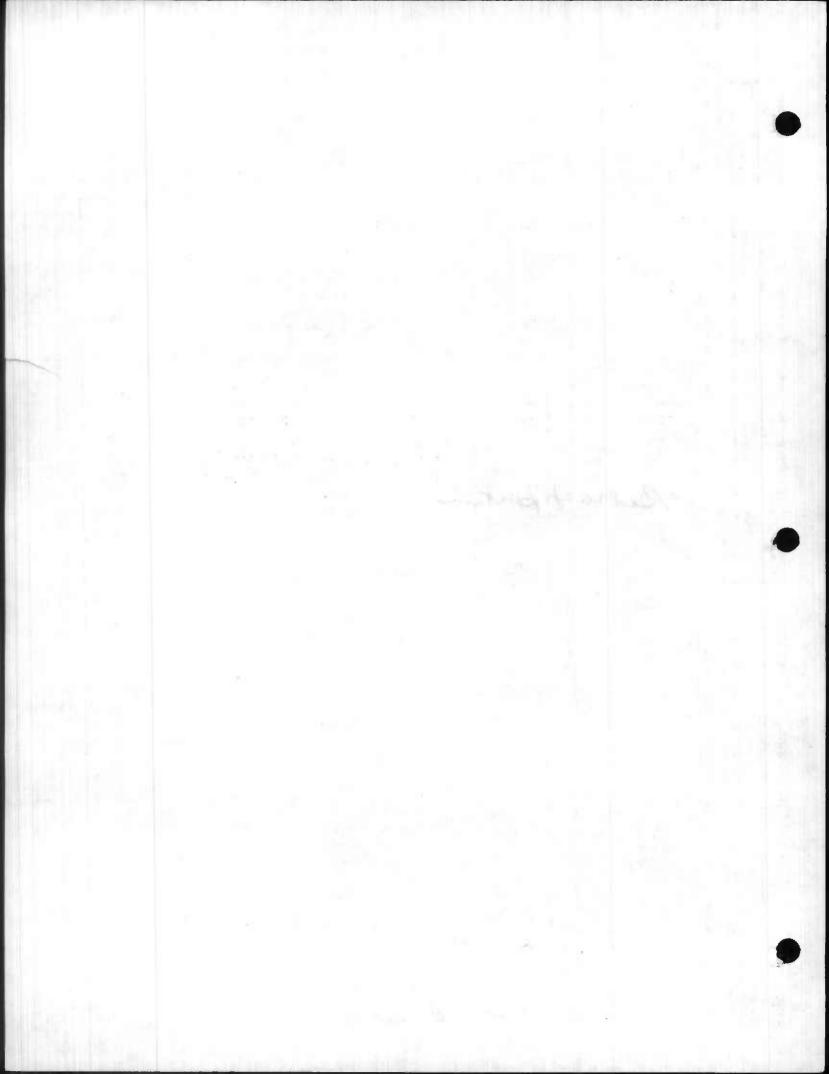
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ANNapolis Rd. Bladensburg, MD



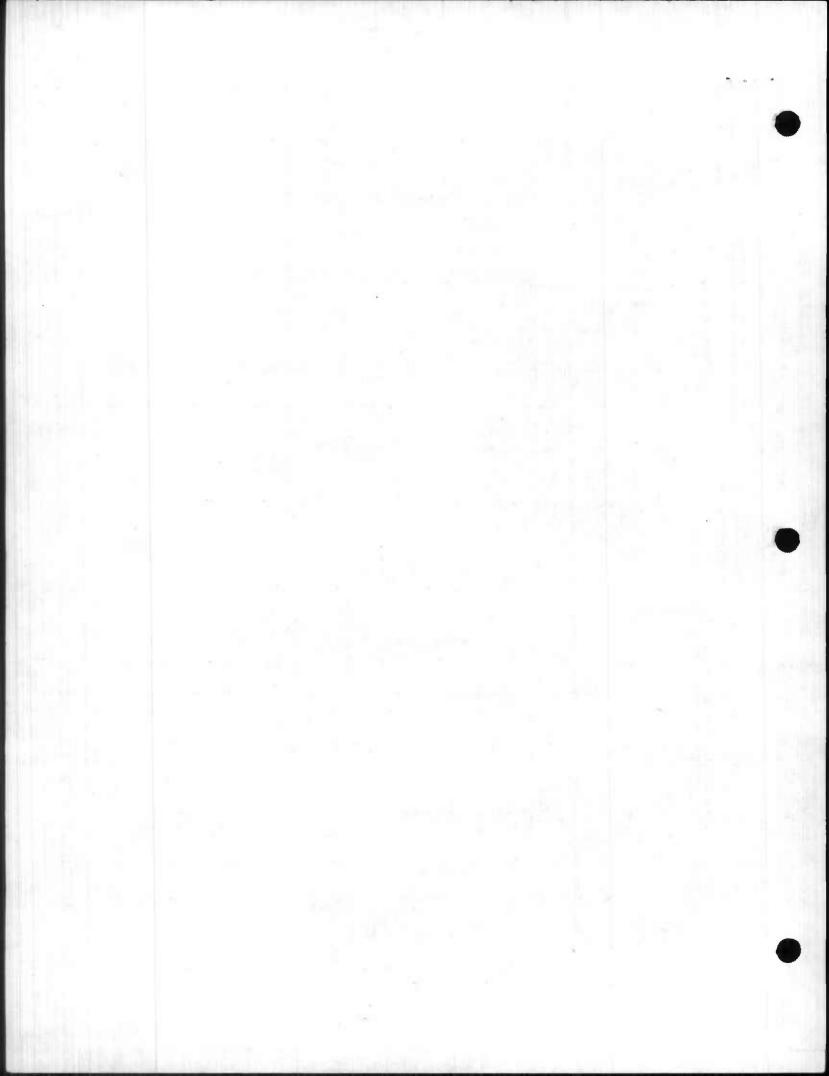
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** CORNEY HAZEL 9:28 AM PECEMBER 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LANHAM PRINCE GEGRGES MAGNOLIA CENTER NURSING HOME If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 10M 20 F 80 Director 241-08-2725 June 18,1920 South Carolina Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at 1 X Yes 2 No Director prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? munitibe of 1328 Nicholson Street 20782 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 14 Race - American Indian 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 □ Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none None None Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) parmit. Pages 1 and 2 should be fits. Department of Health and Mental Hy Important: if them 27 is marked other any injury or other traumatic event. Be Ed Corney Mary Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester W. Corney /Brother 1328 Nicholson St, Hyattsville, Md, 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Olivet Cemetery 12/29/00 Washington D.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Inc. 716 Kennedy St., N.W. Wash. D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final ACCIDENT hour CEREBROVASCULAR disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be axecuted the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): and Box 68760, Physician/Medical Due to (or as a consequence of): 80 for usa P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funaral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b Time of Aftar ! 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 | Yes 2 | No death. 2 Accident s after death 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral E Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier complataly (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MP DECEMBER 27, 2000 D50343 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOWIE, MARYLAND 20715 SUPERIOR A-6 KELVIN HAO MD 3231 LANT ISUITE 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State DEC 2 8 2000 Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Examine	r	4e Facility Neme (I	f not institution, gi	va street and numb	er)			4b. City, Town, or I	ocation of Death	4c. County of	Death
					ospital (			and the same of th	Cheverly	_	Prince	
	Funeral Director		5. Social Security N 577-32-85	60	Sex 7.	Age (In yrs. le	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day April 30	,1933 un	Birthplace (State or Foreign Country) obtainable
	death with the Meryland me 23a or 28a4 show merat be notified at neral Director		Usuel Residence of 10a. State	10b. County			, Town or Lo					10d. tnside City Limits 1 ☐ Yes 2 ☐ No
	or 28a-f	200	Maryland		eorges	Hyatt	svill	7				Λ.
	Vict to	5	10e. Street and Nur					10f. Zip Code			log. Citizen of Wha	at Country?
	a 23a			fferson		C 1- 11 C	140.1	20782	F		U.S.A.	American Indian,
020	5-0020 72 hours effer vatural, or te	2	11. Merital Stetus  1XX Nevar Marri 3  Widowed	ed 2 Married 4 Divorced	12. Wes Decede Armed Force 1 Yes 2 If Yes, Give Year or Dete	es? ONo	'	Yes Decedent of I f Yes, specify Cub I ☐ Yes 2 XNo	dispanic Origin? (Span, Mexican, Puerle Specify:	Rican, etc.)		White, etc. white
21215-0		pateldu	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)			or 5+)	(Give		during most of world)	king	16b. Kind of Busin	
7	Hygie Hygie Ther t		unobtai 17. Father's Name (		01		uno	btainabl		o /First Middle	unobtain Maiden Sumame)	able
Maryland	and Mentel Hygi le marked other surnatic event,	6		tainable						nobtaina	· ·	
2	should in Men	-	19a. Informant's Na	me/Reletionship	(Type, Print)		19b. Mailin	ng Address (Street	and Number or Ru			ate. Zio Code)
	nd 2 i		Susan Fle			an			land Ave.			
re,	item othe		20a. Method of Disp			000	ace of Dispo	sition (Name of natory or other pla	ce) I	Data	20c. Location - Cit	y or Town, State
altimore,	Page net c int: If			Cremetion 3 [ 5 Other (Speci	Removel from Ste				ory Decem	ber 26,2	2000 Bren	twood,MD
Bait	permit. Pages 1 and 2 should be filed Department of Heelth and Mentel Hyg Important: If Nem 27 is marked other any Injury or other treumatic event, page.		21. Signeture of Fu	nerel Service Lion	000	0	1 .		ess of Facility Ft.			Home
/		1	23a. Part1. Enter the shock, or hear	ne disease, or con	polications that cau	sed the death.						Approximate
	Physician		shock, or hear	t Jailugs. List only	one cause on eec	h line.						Onset and Death
	/Medical		Immediate Cause (I			M	1114	54-1000	. Lait	INP		dayo
	Examiner		resulting in death)		8).	Due to (or	es e conseq	Sty Teer (Lighter of):	y coa			The state of the s
١.	D = 0					Re	eun	end for	remone	9		mercel
	physician and sthe buriel-transit	2	Sequentially list cor	nditions,	U	Due to (or	es a conseq			0	1	
60,	be ed ician burka	2	Sequentially list conditions, if enry, leading to immediate cause. Enter Undertying Cause (Disease or Injury thet initiated events resulting in death) Last  Due to (or es a consequence of):  Severe Chronic Olic Tructer  Due to (or as a consequence of):  Cuycase							we leing	years	
68760,	ficete be physicial sthe burn	2	thet initieted events resulting in death) L	ast		Due to (or as a consequence of):				liséase		
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0	let the death certi d by the attending etached for usa e	7.0	Part II. Other signifi		A .						_	Drobably 4 Unknown
P. P.	5 00		alle	e reca	Jeulen	c, Ca	relia	e clips.	Thima	150	95 2L NO 3	
Records,	been shoul		mal	nu to to	jeulun ion, au	rollare	ia,	Dem	rutia.	24a. Was perfor	an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
R	The lew ate has page 2	5								101	es 20(No	1 ☐ Yes 2 🕱 No
Vitai	ysician: The lis certificate hadirector, page		25. Was casa referr	ed to medicat					26. Place of Dea	th (Check only o	ne)	
of V	Physician: this certific rel director.		axaminer? 1 ☐ Yes 2 ☐	No	Hospital:	atient 2 E	R/Outpatien	1 3 DOA OH	her: 4 Nursing H	ome 5 Resid	ence 6 Other	(Specify)
Division o	Attending Ph or death. ector: After th by the funerei		27. Manner of Death 1 ⊠Natural 2 ☐ Accident	5 Pending invastigation	983	Day Year)	28b. Time of tnjury		ry et rk? ] Yes 2 □ No	28d. Describe h	ow injury occurred	
Divis	tal or Attending P rs efter death. al Director: After t led in by the funer Certification:		3 ☐ Suicide 4 ☐ Homicide	6 Could not l detarmined	286. Piece of	Injury - At hor , etc. (Specify)	na, farm, str	eet, factory, office		28f. Location (5 City or Tow	itreet and Number n, Stata)	or Rural Route Number,
	n 24 hound no 24 hound he Funer pletely fill	8000	29a. Certifier (Check only one)	1 Certifying Pl 2 Medical Exa	nysician: To tha be miner: On the basi and manner	s of axaminetic	rledge, death on and/or inv	occurred at the ti restigation, in my	me, date and place opinion, death occu	, end due to tha c rred at the time, o	ause(s) and mann lata and place, and	er es stated. d due to the cause(s)
	Within To the Com	1	29b. Signeture end		-	neA		29c. Licens			29d. Date signed (	Month, Day, Year)
			/	all d	uolag	(M)		0	24720		12/1	3/00
		1	30. Name and addre	ess of person who	completed cause of		6).		LEVERLE		A 61 d 2078	>5
	State		31. Deta filed (Mont	h, Day, Year)		istrar's Signatu		-	REVEND	1	a as to	3
	Registrar		DEC	28200	U Som	wa	Ø.	Looks	/			



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Data of Death Month **Physician** Myrtle Brown Collison 27 Dec. 6:15 pm 2000 /Medical 4c. County of Deeth 4e Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Mallard Bay Care Center Cambridge Dorchester 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthpleca (State or Foreign Country) **Funeral** Months Deys Hours 1 M 2 F Yrs. 83 220-10-6683 April 11 1917 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 X No Director Dorchester East New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5633 Beach Haven Road 21631 U.S.A. Items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 14. Race - American Indien, Bleck, White, etc. 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 specify: white ò 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced be filed within 72 hours tal Hyglene.
d other than "natura event, the Medical E Completed 16a. Decedant's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) garment mfg. seamstress 18. Mother's Name (First, Middle, Maiden Surnama) 17. Fathar's Nema (First, Middle, Last) es 1 and 2 should be for the that the th Bernard Brown Sr. Ann Gertrude Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5633 Beach Haven Rd, East New Market, MD 21631 James D. Collison - husband 20b. Piece of Disposition (Neme of cematary, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Steta Pages 1 Department of Important: If its any injury or o Buriat 2 ☐ Cremetion 3 ☐ Removei from State Dorchester Memorial Park 12-30 Cambridge, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home, PA 21. Signeture of Furfaral Service Licensee 700 Locust St., Cambridge, MD wall 23a. Pert1. Entar the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** Immediate Cause (Final diseasa or condition rasulting in death) UYOSepsis /Medical Ohe Week Examiner Due to (or as a consequence of): Metastate Breage Moules Examiner physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury Dua to (or as a consequence of) be exect 68760. Physician/Medical that initiated evants resuiting in death) Lest Due to (or as a consequence of) Box P.O. Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause givan in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknown been signed by should be dated by Records, 24b. Wara eutopsy findings avaitable prior to completion of cause of death? 24a. Was an autopsy performed? Completed рада 1 Yas 2 TNo 1 Yes 20 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Tursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 28a. Dete of Injury (Month, Dey Year) 27. Mannar of Death 28c. Injury at Work? 28d. Describe how Injury occurred edical Certification: I or Attending P after death. Aftar Division 5 Pending Investigation 1 Salaturel 1 ☐ Yes 2 ☐ No 2 Accidant Director: 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 6 Could not be 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours a To the Funeral Complately filled in the Funeral Complately filled in the second seco 1 Cortifying Physician: To the best of my knowledga, deeth occurred at the tima, data end piece, end dua to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daath occurred at tha tima, data and placa, end dua to the ceuse(s) and menner steted. 29a. Certifiar 29b. Signature and titla of certifly 29c. License number 29d. Date signed (Month, Day, Year) MO 12-28-00 D 47924 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) STREET CAMBRIDGE MD 2/6/3 300 AURORA NOMAN THANNY

**DHMH 16 Rev 6/95** 

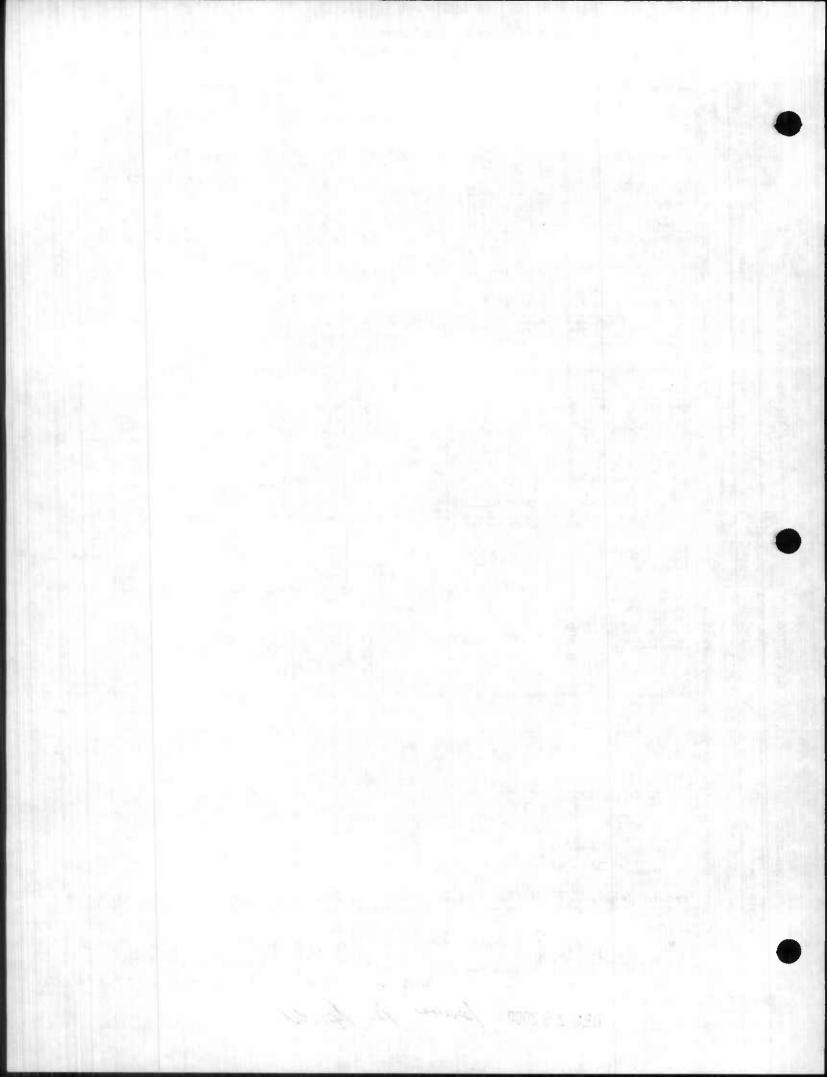
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Registrar

31. Dete filed (Month, Day, Year)

32. Registrer's Signature

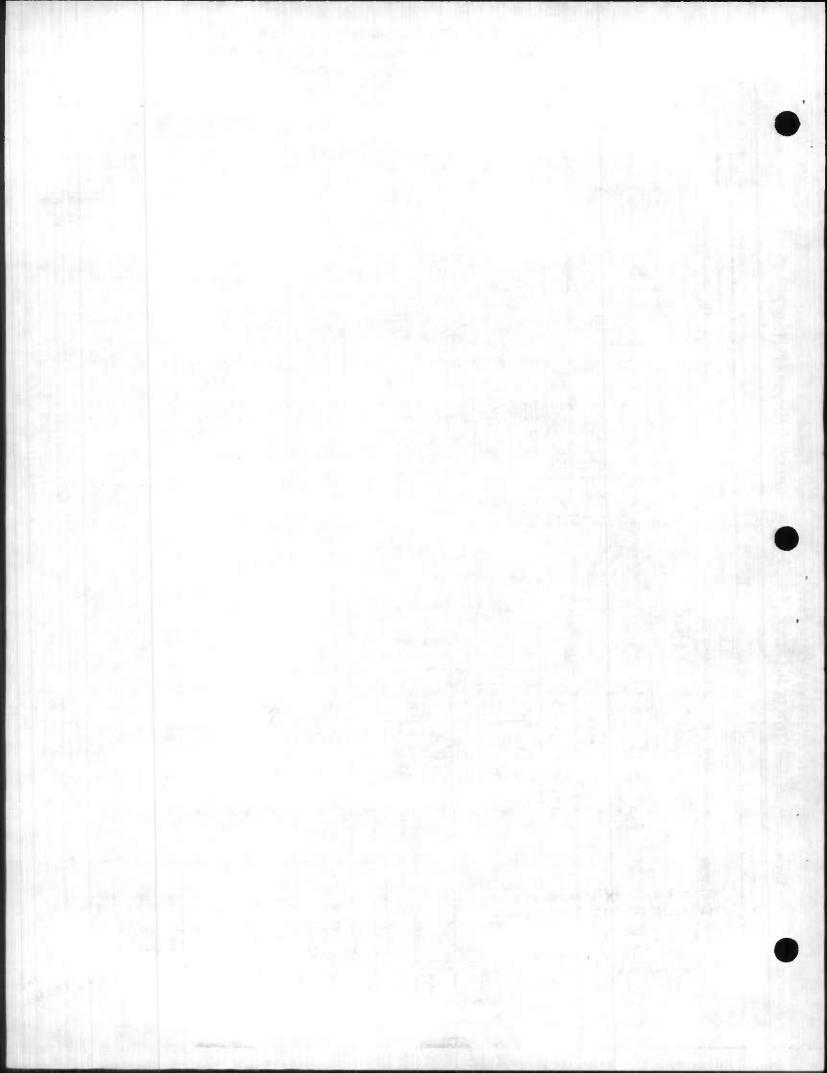
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State of Maryland / Department of Health and Mental Hygiene 0 42945

						Ce	rtificate o	f Death		Reg. No.	only from	
	Physicia	'n	1. Decedent's Neme (First, Middle, I		0				2. Dete of I	mber 29	2440	3. Time of Death 5:53A.
0	/Medic Examin	al	Naomi Emma  4e Fecility Neme (If not institution, g Suburban Hospit		Casmar	1		4b. City, Town, Bethe	or Location of De	ath 4c. Cou	nty of Death	
	Funeral Director			Sex	7. Age (In yrs. I	last birthday) O Yrs.	If Under 1 Ye		Hrs. 8. Dete of In (Month) NOV • 2	Birth (1910		lece (Stete or Foreign
			Usual Residence of Decedent 10a. State 10b. County Maryland Montgom	nerv		, Town or Lo					10	0d. Inside City Limits 11∕ Yes 2 No
	deeth with the Maryland ms 23s or 28s-f show	Director	10e. Street and Number 2708 Ross Road	ica y	pric v <sub>2</sub>	Onab	10f. Zip Code 2081				of What Coun	
020	5 2 2		11. Merital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	Armed F	1 Tyes 2 YNo		   Was Decedent of Hispanic Origin? (Specify Yorks, specify Cuben, Mexican, Puerto Rican, I □ Yes 2 □ No Specify:					
1215-0	within 72 ho ene. than *natur	Completed	15. Decedent's (Specify only highest g	arade completed	(1-4or 5+)	(Give	kind of work don DO NOT use ref	Isual Occupation work done during most of working T use retired)  Educati				lustry
Maryland 21215-0020	d be filed w ental Hygier ted other th c event, tra	o Be Cor	Elementary/Secondary (6-12) College (1-4or 5+) 4+ Teacher  17. Father's Name (First, Middle, Last) Max Richman  College (1-4or 5+) 4+ Teacher  18. Mother's Neme (First, Middle, Maiden Rosa Marymore						fle, Maiden Sum			
Mary	nd 2 should lith and Men 27 Is marke r traumatic	F	19e. Informent's Neme/Relationship Elizabeth Casman		rs — Dau				Rurel Route Nur Pittsbur			
Baltimore,	Pages 1 and of Heam of Hemility or other		20e. Method of Disposition  1 Disposition  2 Cremetion 3  4 Donation 5 Other (Special Control of Co	☐Removel from	CI CI	emetery, cre-	osition (Neme of matory or other p id Memo	oleca) rial Gar	Dete		on - City or To	wn, State Ch, Virginia
Balti	permit. Page Department: Important: If any Injury o		21. Signature of Paneral Service Lio	Way d	lus			_	rdt Fune Rd. Bel			land 20705
4	Physician		23a. Pert1. Enter the diseese, or co shock, or heert failure. List on	mplications thet ly one ceuse on		n. Do not en	ter the mode of o					Approximate Interval Between Onset end Death
AM	/Medical Examiner	er.	Immediate Cause (Final disease or condition resulting in death)	a	SE Due to (o	os a conse						
50		Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events  b									
09/89 x	E 0.0	Medical	thet initieted events resulting in death) Last  Due to (or as e consequence of):									
12/2/29 .0. Box	iras that the deeth cert signed by the attendin d be detached for use	Physician/M	Pert II. Other significant conditions	contributing to	death but not resu	ulting in the u	underlying cause	given in Part I.				the causs of death?
/ rds, P	gne th	P	OLSERE ALZHEIMER'S DISEASE 24e. Wes en autopsy performed? 24b.								24b. We	ere eutopsy findings aiteble prior to
Reco!	The law require ta has been si bage 2 should I	Completed	CLOSTRIDIUM	1 DIF	FICIU	E E	NTERO	COLIT	70	Tyes 2-1871	of	mpletion of cause deeth?
FVital	ystclen: is certific director	To Be C	25. Wes case referred to medical examiner?  1 \( \text{Yes} \) Yes	Hospitel:	Inpatient 2	ER/Outpatie	nt 3 DOA	Wher:	Death (Check on		Other (Specify	y)
Sman Nagmi E.N. E.N. E.N. E. Division of Vital Record	After fune	Certification:	27. Manner of Death  1-Xeturel 5 Pending 2 Accident 3 Suicide 6 Could not determine	be 28e. Plac	e of Injury nth, Dey Year) be of Injury - At ho ding, etc. (Specify		M 1	ijury et Vork? ☐ Yes 2☐ No	28f. Location	n (Street and Nu		al Route Number,
Car	Hospi 24 hou Funer stely fill	edical Ce		aminer: On the					leca, end due to to occurred at the tim			
•	To the comple	Mec	29b. Signature and title of pertifier	Nz	or orașed.		29c. Lice	265	71	29d. Date sig	gned (Month,	Day, Year)
			30. Name and address of person wh	1507	MD	4938	Print	RAYA	VE. B	ETHES	OA, N	10208/4
	Stat Registra		31. Dete filed (Month, Day, Year)	General 32.	Registrer's Signe	Apon	Ks				771.	



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 3. Time of Death 2. Deta of Deeth Month **Physician** Catherine Ferguson Delano 7:35 P.M. December 21, 2000 /Medical 4b. City. Town, or Location of Deeth 4e Facility Nama (If not institution, give street end number) 4c. County of Death Examiner Prince Georges Lanham Magnolia Gardens If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Nova Scotia 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months 1□ M 25 F 79 012-12-8027 January 6, 1921 Director Usual Rasidenca of Decedant 10b County 10c. City, Town or Location 10d. fnside City Limits 28a-f ahow Maryland Prince Georges Seabrook 1 N Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? "naturel", or items 23s or 9408 Wellington Street 20706 United States Funeral 14. Rece - American Indien, Black, White, atc. 12. Was Decedant Evar in U,S Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status filed within 72 hours after 1 ☐ Yas 2 ☑ No If Yas, Give Yeer or Detas: 1 Nevar Married 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Accounting 12 17. Fether's Neme (First, Middle, Lest) 18. Mothar's Nama (First, Middle, Maiden Surnama) permit. Pages 1 end 2 should be i Department of Health and Mentel I Important: If Hem 27 Is marked or any Injury or other traumatic ave Maude Wilson William Ernest Ferguson 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Streat end Number or Rural Routa Number, City or Town, Stata, Zip Code) Norris B. Delano/ Husband 9408 Wellington Street Seabrook, MD 20706 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Dete 20c. Location - City or Town, State Geo. Wash. University Medical Center 1 Burlal 2 Crametion 3 Ramoval from Steta Washington, D.C. 4 Donation 5 ☐ Othar (Specify) Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 of the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, heart failure. List only one cause on each line. Approximate fntarvel Between Onset and Death **Physician** /Medical Immediata Causa (Final Sepsis disease or condition resulting in death) Examiner Physician/Medical Examiner MOS renou Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated avents resulting in death) Last P.O. Box 68760, herol rabetes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? Rheumatoid Arthritis 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Be Completed by 24b. Ware autopsy findings available prior to completion of cause of death? old Righ Above-Knee Amputation 24a. Was en eutopsy Hyperlipidemia. 1 Yes 2 No 1 Yas 2 No Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certifica 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Date of Injury (Month, Dev Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Panding invastigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of fnjury - At homa, farm, atreet, factory, office building, atc. (Specify) To the Hospital or A within 24 hours after To the Funeral Directorn plately filled in b 4 Homicide 1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, data and place, and due to the ceuse(s) and mennar es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29e. Certifier 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifia 128100 D31001 and cause of death (Item 23a) (Type, Print) 7500 Green way Catr. Dr. #430 s of person who comp Turkewitz, Greenbelt, MD. 31. Dete filed (Month, Dey, Year) DEC 2 9 2000 32. Registrer's Signature State

**DHMH 16 Rev 6/95** 

Registrar

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Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend#'s 18.20a.20b.& 20c.Per FH PGC 12-29-00 Gertificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey 18, Yeer 2000 Physician 8:27 A.M. Mary Davis /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Cheverly Prince George's 7. Age (In yrs. last birthdey). If Under 24 Hrs. Birthplace (Stete or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1□M 2XF 218-30-4979 Yrs. Director Wash., D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow Md. P.G. Glenarden Yes 2 No Director 288-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23s or 8623 Glenarden Parkway 20706 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian. Black, While, etc. 1 ☐ Yes 2 XNO If Yes, Give 1X Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black À 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Domestic Worker Private Industry permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Isem 27 is marked othe any injury or other treumatic event once. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 8 Frederick Burroughs Mary Agnes Dent 19e. Informant's Name/Relationship (Type, Print)
Francis Saulsbury/Niece 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1101 Nalley Rd. # 1013, Landover, Md. 20785 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Glenwood Cem. 12/29/00

Hesapeak Crematory 12-30-00

Lame and Address of Facility

22. Hame and Address of Facility

4925 Burroughs Ave., N.E., Wash., D.C. 20019 + XBorial 2 X Cremetion 3 Removal from State Washington, D.C. Beltsville Md. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeak 21. Signature of Funeral Servica Licensee W. Srall arre 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Myscordial Interestion /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es e consequença of): Examiner physician and s the burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequenca of): 68760 Physician/Medical Due to (or as a consequence of): Box Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? De a dent signed by (erevior as culo 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Were autopsy findings evailable prior to completion of ceuse of death? Completed 24a. Wes en autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mannes of Deeth 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending Investigation or Attending To the Hospital or Attending within 24 hours after death.

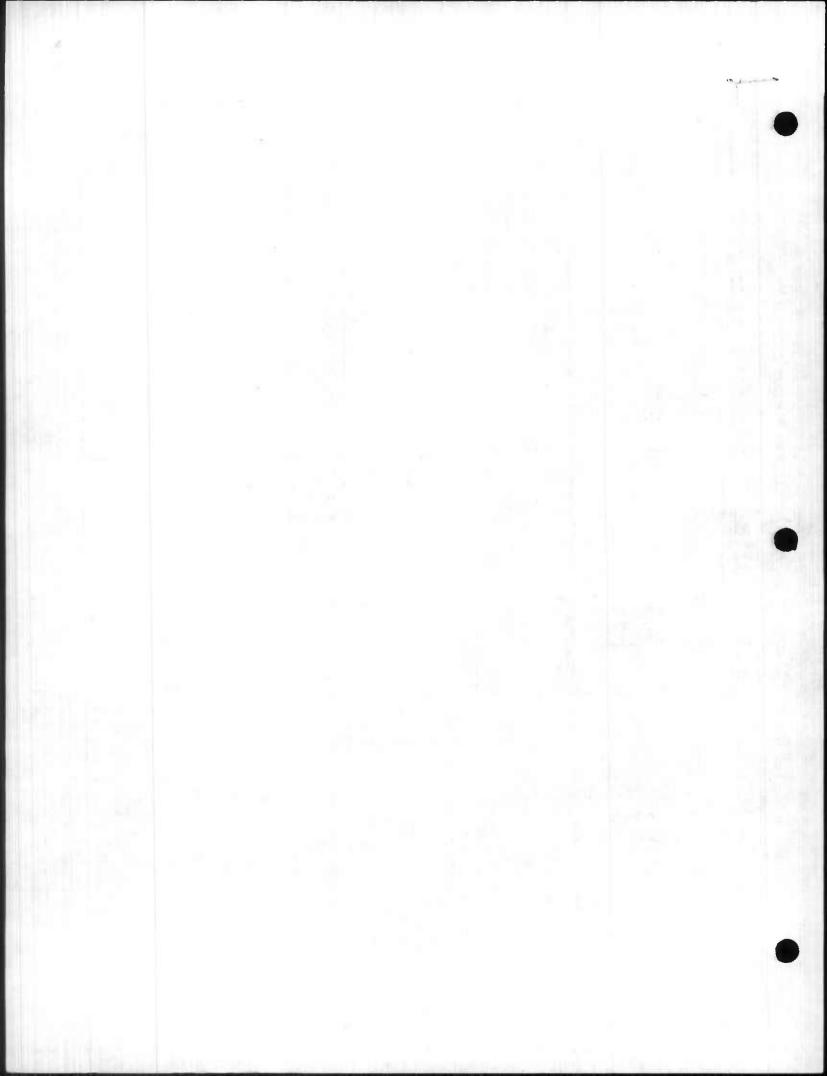
To the Funeral Director: After completely filled in by the funeral process. 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Cortifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 72507 00 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ix curtive place Lanton no 20704 Don H. Yablansuch tops mo

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year)
DEC 2 2 2000

Registrar's Signeture

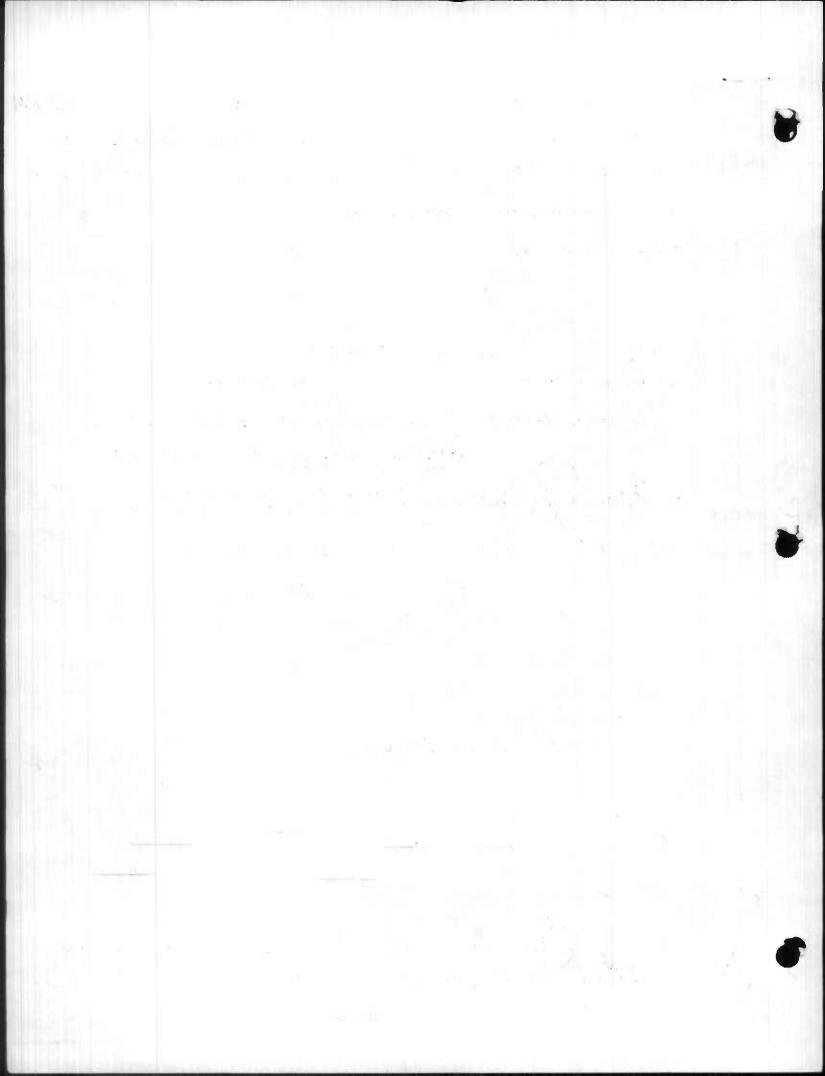


Amend #8.Pe	State r FH PGC 12-26-2000 cr	e of Maryland / Dep Co	partment of Fertificate of		tal Hygiene	42948		
The manyani A	Decedant's Nama (First, Middla, Last)				Data of Death	3. Tima of Death		
Physician	GERTRUDE EVELYN DOWN	NING			Month Day cember 19, 2	Year 1000 10:35 P.M.		
/Medical Examiner	4a Facility Nama (If not institution, giva street and	d number)		4b. City, Town, or Location				
	PRINCE GEORGE'S HOSP	ITAL CENTER		Cheverly		George's		
Funeral	5. Social Sacurity Number 6. Sax	7. Aga (In yrs. last birthda	y) If Undar 1 Yaar Months Days	If Undar 24 Hrs. 8. [ Hours Min. (	Data of Birth Month, Day, Year)	Birthpleca (Stata or Foraign Country)		
Director	Usual Rasidence of Decedent	84 Yrs.		Oc.	t. 141916	Washington, D.C.		
pue *	10a. Stata 10b. County	10c. City, Town or	Location			10d. Insida City Limits		
the Maryler 28e-1 show nourse	Maryland Prince George	Conito	1 Heights	1⊠Yas 2□				
the north	10e. Street and Number	S Capita		What Country?				
death with the Maryland ims 23s or 28s-f show control of the condition of	1919 Nova Avenue		748	States				
Ifter death with the Ma freme 23a or 28a-1 s their must be notified Funeral Director		Dacedant Evar in U,S. 13	3. Was Decedant of H	lispanic Origin? (Spacify an, Maxican, Puarto Rica	Yas or No- 14. Rac	ce - Amarican Indian, ck, Whita, atc.		
5-0020 72 hours after natural; or its same after by Fu	1 Navar Married 2 Married 1 1	/as 2⊠ No s, Giva	1 ☐ Yas 2 ☑ No			y: African		
21215-0020 d within 72 hours at giene. It then "natural", or it th	3 Widowed 4 □ Divorced Yaar	or Datas:	12 143 232110	ориону.		erican		
1 21215-002 led within 72 hours lygiene. ner than "natural", nt, the Medical Ex-	15. Decedent's Education (Specify only highast grada comple	ted) (Gir	cedant's Usual Occup va kind of work done DO NOT usa ratire	during most of working	16b. Kind of B	usinass/Industry		
within see. then then main	Elementery/Secondary (0-12) Colla	Collaga (1-4or 5+)		a)				
d 21 filed w Hygien ther th ent, the	17. Fathar's Nama (First, Middla, Last)	F	Educator	18. Mothar's Nama (Fin	Priva st, Middla, Maiden Sumer			
yland ould be fil Mental H merked oth arke oven	Samuel Henson			Trene	Davis			
Maryland 212 nd 2 should be filed within th and Mental Hygiene. Traumed cother than traumetic event, In-M. To Be Comp	19a. Informant's Name/Relationship (Type, Print,	) 19b. Ma	illing Addrass (Street		uta Number, City or Town	, Steta, Zip Code)		
■ 550 ±	Khalil Hassan - Son	нс з	2 Box 535	Madison V	irginia 227	27		
Baltimore, Nomit. Pages 1 and Department of Health Inportant: if item 27 in piloty or other trans.	20a. Mathod of Disposition	20b. Placa of Dis	position (Nama of rematory or other pla	ce) D	ata 20c. Location	- City or Town, Steta		
Page sent of int: if	1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval f 4 ☐ Donation 5 ☐ Other (Specify)	rom Stata	Crematory		6/2000 Clin	ton, MD		
Baltimo parmit. Pages Depertment of Important: if I any injury or and	21. Signatura of Funaral Sarvice Licenses	ass of Facility						
Ball Depe	I Gol T Story	~ + TT	STEWART F	UNERAL HOME	, Inc.			
	23a. Pá/11. Enter tha diseasa, or complications to block, or haart failura. List only one causa	hat causad tha daath. Do not a	antar tha moda of dyi	ng, such as cardiac or ras	.E., Washing	Approximata Intarval Batween		
P.O. Box 68760, at the death certificate be assouted by the attending physician and etached for use as the buriel-transit physician/Medical Examiner	Immadiata Causa (Final disaasa or condition rasulting in daath)  Sequentially list conditions, if any, leading to immediata cause. Entar Undarlying Cause (Diseasa or Injury that initiated events rasulting in death) Last  d.	Due to (or as a cons	sequance of):	CANC	Y GMBI	Onsat and Death OLI (5 PAYS		
Geath death of for	Part II. Other significant conditions contributing	to death but not resulting in the	undadving ceusa gi	van in Pert I.	23b. Did tobacco use co	ontribute to the cause of death?		
	PERIPHER				1 <b>70</b> Yse 2□ No	3 Probably 4 Unknow		
Division of Vital Records, P.O. Box 60 or Attending Physician: The law requires that the death certific and death.  Director: After this certificate has been signed by the attending plant of the funeral director, page 2 should be detached for use esterification: To Be Completed by Physician/Mecertification:	ATRIAL	FIBRILL	ATION	,	24a. Was an autopsy performad?	24b. Wara autopsy findings available prior to completion of cause of deeth?		
f Vital Record ysician: Tha law requir is certificate has been si director, page 2 should To Be Completed	TOBACCO	ABUSE			1□ Yes 2 No	1 Yas 2 No		
Vita clan: clan: entific ector,	25. Wes case raferred to medical axaminar?	700	O	26. Plece of Deeth (Cl	neck only ona)			
of very signature of this of all directions of the thi		1 Sunpatiant 2 ER/Outpet	ient 3LI DOA		5 Rasidance 6 Ott			
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Or A or A sin by Sin by	4 Homicida datarmined 208.	Place of Injury - At homa, farm, building, atc. (Spacify)	straat, lactory, omco		City or Town, Stata)			
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New York Man	29b. Signatura and titla of course		29c. Licans	sa number		ed (Month, Day, Year)		
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(2)	30. Neme end eddrass of person who completed		50 MER	CANTILG	LANG.	ARGO MO.		
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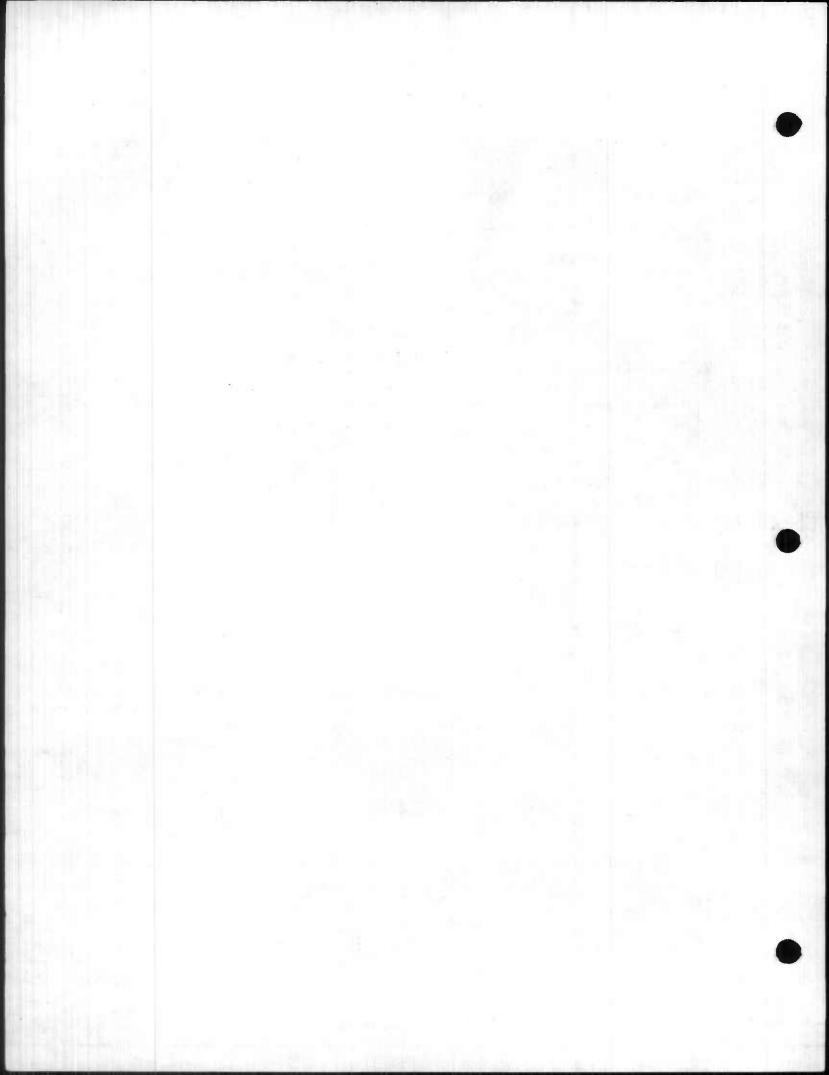
Physician /Medical	1. Decedent's Name (First, ALBERTA	Middle, Last) S . DAV	IS	?7 <b>-</b> 2000 d					2. Date of D Month 12	Dey 21	2000	3. Time of Death 5; 50 P.
Examiner	4e Facility Name (If not ins			7)		4			ocation of Dee		County of Deeth	
Funeral Director	Fort Washing 5. Social Security Number 255-74-8457	6. Sex		nge (In yrs. last bi	irthday) If Unde Months	er 1 Year Days	If Under Hours		8. Date of Bi (Month, D 12-14-1	irth ay, Year)	9. Birth	eorge's  place (State or Foreign unity)  Ville, GA
Director	Usual Residence of Decede	ent		02					12-14-1	. 510	neys	ville, Gn
the many and the state of the s	10c. State 10b. County 10c. City, Town or Location Fort Washington										10d. Inside City Limits  19€ Yes 2 □ No	
ret must be noticed function Director	9711 Jacqueline Drive				10f. Zip Code 20744				10g. Citizen of What Co USA			untry?
by Funeral		11. Marital Status  1 Never Married  12. Was Decedent   Armed Forces?  1 Yes 2\( \) Married  1 Yes 3\( \) H Yes Give			i. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuben, Mexican, Puerto							e, etc.
peted		3 Widowed 4 Divorced Year or Detes:			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				ing	16b. Kind of Business/Industry		
Comp			College (1-4or	54)	Hous	sewif		ara Mara	e (First, Middle	Own	Home	
To Be C			n						Single		umette)	
traumatic event, I	19a. Informant's Name/Rel George Davi				b. Mailing Addres							
any injury or ower u	20a. Method of Disposition  1 Burial 2 Crem  4 Donation 5 Ot	ation 3 Rem		20b. Place of	11 Jacque of Disposition (Na Bry, crematory or Grove Bapt	am <i>e of</i> other plac	ce)		Pt. Was Date 2-27-00	20c. Loca	ID 2074 ation - City or I 111e, GA	
drug physician and Medical Examiner	23a. Part1. Enter the disease shooting the heart failure	ase, or complican a. List only one o	one that cause	ed the death to	719 Ker	J. I					20011	Approximete Interval Between
edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	a b c d	Ac Si	Due to (or as a PS IS Due to (or as a Due to (or as a Due to (or as a	My 0 CAN consequence of consequence of)  Litter consequence of)	Dec	po po	ENF.	or Mash	and C		Interval Between Onset end Death
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		State of Maryland	•	nt of Health an te of Death	d Mental Hy	giene. Reg. No	42950		
Physician /Medica	CFUDITATION	DAW	ISON		2. Dete of De Month (2	22 2	Year 2:30PM		
Examine	de Casilla Mana /Mant institution six		SINC Conto		or Location of Deat				
Funeral Director	5. Social Security Number 6. S			er 1 Year   If Under 24		th ly, Year)	9. Birthplece (State or Foreign Country) Grifton, N.C.		
p M	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits		
death with the Maryland me 23a or 28e-f show must be notified at	District of Col	umbia	Washingto	n Code		10g. Citizen of W	1 ☑ Yes 2 ☐ No		
h with	1609 17th Place	. S. E.		20020		United			
020 urs after alr, or its	11. Marital Status  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1⊠ Yes 2 □ No If Yes, Give Year or Dates:	S. 13. Wes Dece It Yes, spe 1 \( \subseteq Yes	edent of Hispanic Origin ecity Cuban, Mexican, P 2 No Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Race Bleck Specify:	- American Indian, k, White, etc. Δfrican		
15-0 n 72 ho n retur	(Specify only highest gra	15. Decedent's Education (Specify only highest grade completed) (Give kind life. DO h				16b. Kind of But			
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Marylanc 42 should be fi h and Mental It I e marked ot treumetic aver	Joe Daws  19a. Informent's Neme/Relationship (		19b. Meiling Addres	Has (Street end Number o	attie Cole	9-	Stete, Zip Code)		
Baitimore, Maryiand 212 permit. Pages 1 and 2 should be filled withit Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than and. To Re Comp	Beverly Spencer—  20a. Method of Disposition  1 Burial 2 Cremetion 3 Company  4 Donation 5 Other (Specify	Rollins - Niece 20b. Pte	e 1609 17 ace of Disposition (Na metery, cremetory or	th Place, Some of other place)	S. E., Was	shington, 20c. Location -	D. C. 20020 City or Town, State		
Baiti pemit. Departm Importa any Inju	21. Signature of Funeral Service Licer	pooled mathington democraty 12/20/00 Adelphil, Ab							
Physician /Medical Examiner	23a 1.1. Enter the disease, or complete, or heart tailure. List only the tailure and tailu	PNEMO	. Do not enter the mo	de of dying, such es car	rdiac or respiretory e	rrest,	Approximate Interval Between Onset end Death 2 Wks		
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0 5 5 5	resulting in death) Last	Due to (or a	as a consequence of)						
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aw requires to been standed at the been standed at the been standed at the beat stande	CAD					en eutopsy ormed?	24b. Were autopsy tindings evailable prior to completion of cause ot death?		
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Of Vital I Physician The this certificate ral director, page Co		Hospital: 1 Inpatient 2 E	ER/Outpatient 3 D	Other	Deeth (Check only ng Home 5 ☐ Res		or (Spacifu)		
After fune		28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1 Yes 2 No	7	how injury occurre			
× 5 € 5 5	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, ferm, street, fector	28f. Location City or To	(Street and Number wn, Stete)	er or Rurel Route Number,			
To the Hospital within 24 hours To the Funeral completely filled		nysician: To the best of my know niner: On the basis of examinetic and manner stated.	fledge, death occurred on end/or investigation	l et the time, date end p n, in my opinion, death o	place, end due to the occurred at the time,	cause(s) and med date and plece, e	nner es stated. and due to the ceuse(s)		
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(2)	30, Name and address of person who can be seen and address of person who can be seen and seen	8609 SECON	DINEM	IZ, #404	+B, SIL	VER S	BER 22, 2000 PRING MD20910		
State Registrar	DEA 0 N 0000	32. Registrer's Signetu	La lan						

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State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Momes in Rose Hel M &

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

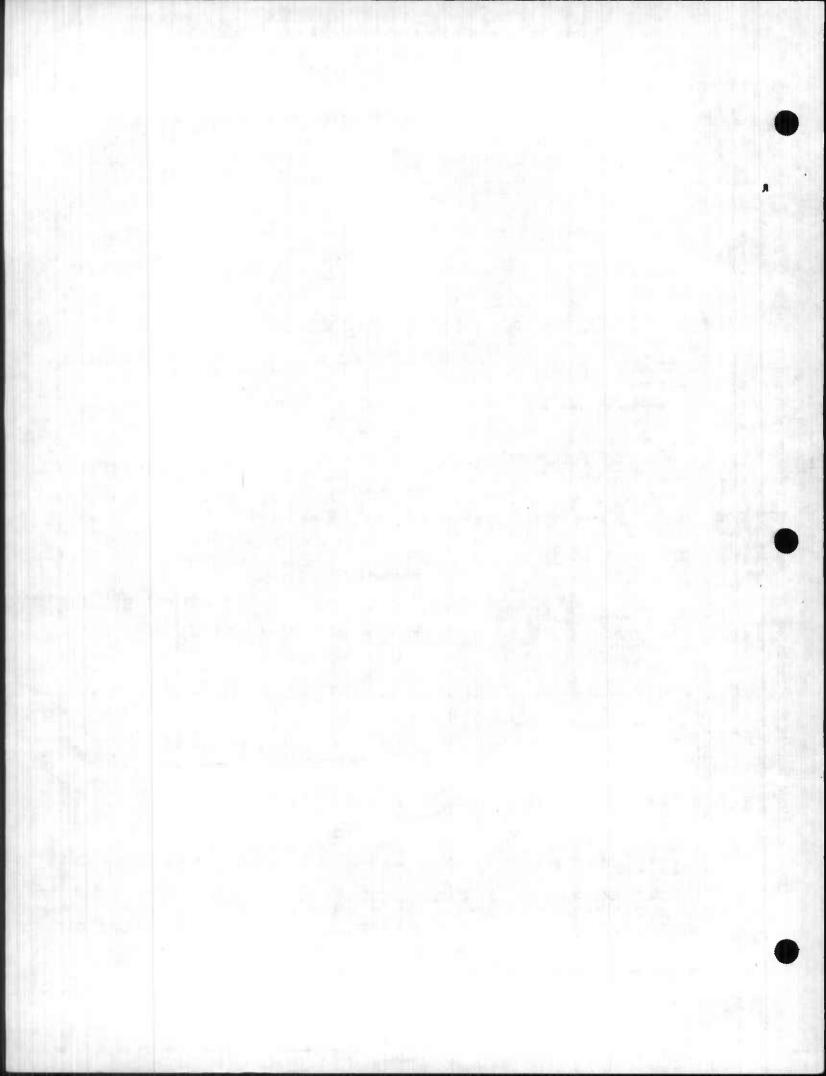
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THOURS IN ROSENTAM 560 RIVERSIDE D- S.B 206 SALISBURY MD 21801

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Yaar Month Day Marjorie FILIS 9:00 AM 12 23 2000 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore City Baltimore MD Joseph Richey Hospice If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6 Say 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Days Months 1□M 250 F 88 VIRGINIA APRIL 21,1912 577-01-7802 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No NONE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 USA 820 N. EUTAW ST 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 11 Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 Yes 2X No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry PEOPLES DRUG STORE Elementary/Secondary (0-12) College (1-4or 5+) COSMATITION 12 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middle, Last) WILLIAM S. BUTLER LILLIAN SPICER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM A. ELLIS JR. (SON) 1138 SEVERNVIEW DR CROWNSVILLE MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removat from Stata 4 ☐ Donation 5 ☐ Other (Specify) HILLCREST CEMETERY 12/28/00 LOUISA VA 21. Signature of Funarel Service Licenses 22. Nama and Addrass of FacilityARLINGTON FUNERAL HOME Mary E 3901 N. FAIRFAX DR. ARLINGTON VA 22203 Ke; many 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Causa (Final diseesa or condition rasulting in death) Senile dementia years Due to (or as a consequence of): Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Dehydration 24b. Wara eutopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Depression 2 0 No 25. Was casa refarred to medical axaminar? 1 Yas 2 XNo 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Dother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending investigation 1 Netural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760,

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Baltimore, Maryland 21215-0020

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Certification:

29a. Certifier

(Check only one)

29b. Signature and title of certifier Tala

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29c. License number

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

D500078

12/23/2000

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

Timothy Polk, MD
31. Data filed (Month, Day, Year)

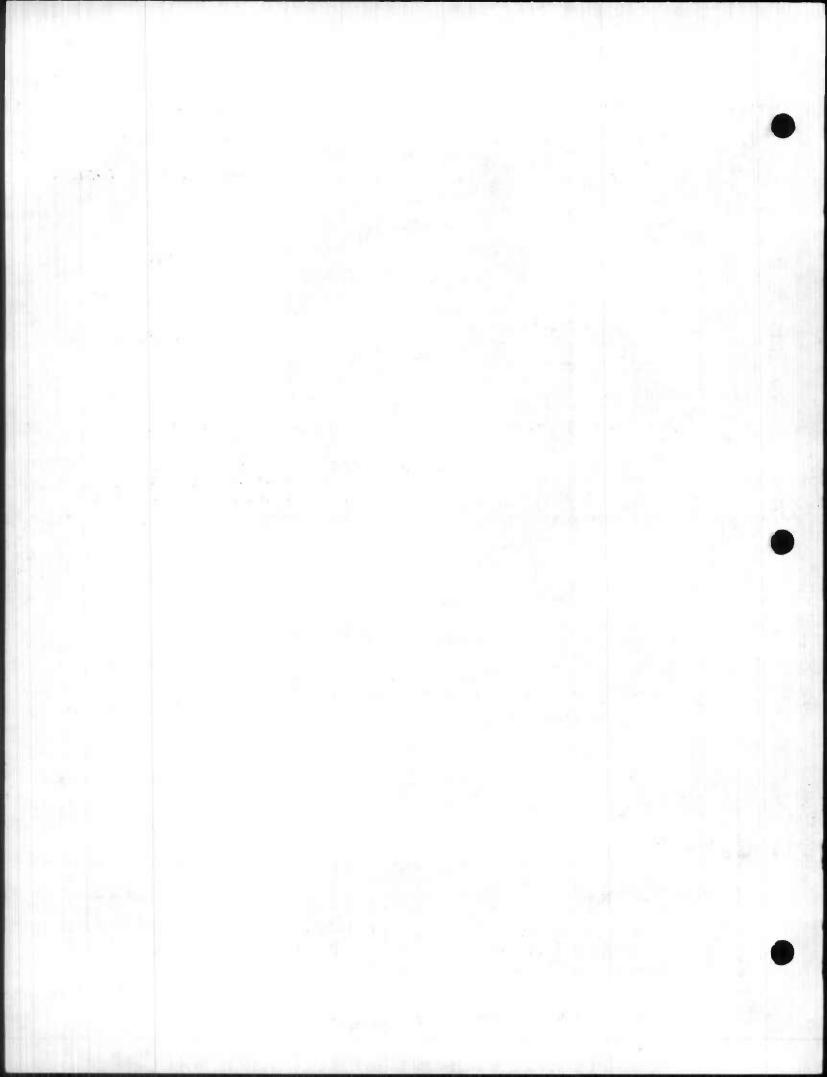
620 Boulton Street Bel Air MD

Sporter

Registrar

DEC 2 6 2000

32 Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yes IVAN ALEXANDER EDWARDS Decem Lev 25 2000 1432 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva straat end number) 4c. County of Death 101 she Hille 100 Prince Georges Southern Avenue Birthplaca (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 7. Aga (In yrs. last birthday) If Undar 1 Yaar 6 Sax Min Months 1₽M 2□ F Days Hours 062-26-5657 67 September 7,1933 New York, NY Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location Prince George's Temple Hills Yes 2□No 10f. Zip Code 20748 10g. Citizen of What Country? 10e. Street and Number 2527 Southern Avenue #102 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: Was Dacadent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes % No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usuai Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Burns Security Security Guard 12 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnema) Beryl Ellis Stewart Edwards 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 4316 23rd Place, Temple Hills, MD 20748 19a. Informant's Name/Relationship (Type, Print) Willie Mae Edwards/Wife 20b. Place of Disposition (Neme of cametery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) 12/27/00 Alexandria, VA Metropolitan Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee CEDAR HILL FUNERAL HOME, INC. Mysel Loutanu wat als 4111 Pennsylvania Ave., Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arteroschentic Cardio VASemlar Disen Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or Injury that Initiated avents resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4☐ Onknown 1 Yes 2 No 24b. Were eutopsy findings available prior to complation of cause of deeth? 24a. Wes an autopsy 1 Yes 2 → No 1 □ Yes 2 □ No 25. Wes case referred to medicet 26. Piece of Death (Check only one) examine es 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidenca 8 Other (Specify) 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Halveturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

**Physiclan** /Medical Examiner and I-transit the death certificete be executed Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or itams 23a or 28a-f ahow

permit. Peges 1 and 2 should be filed within 72 hours effer death to Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic avent, the Medical Exercises 23s and others.

Baltimore, Maryland 21215-0020

Director

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State Registrar 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. (Check only one)

2 Medical Examiner: On the basis of axaminetion and/or investigetion, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier

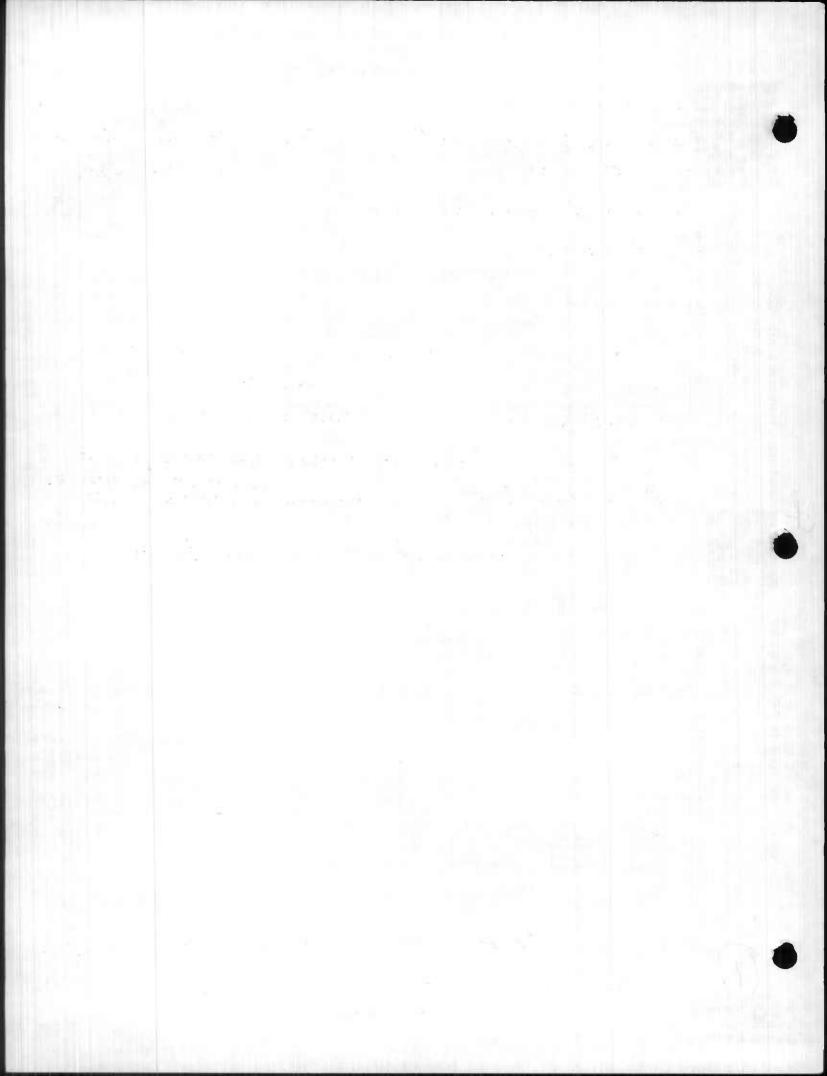
29c. License number 140055927 29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) SALVA don Sylvest
31. Data filed (Month, Day, Year)
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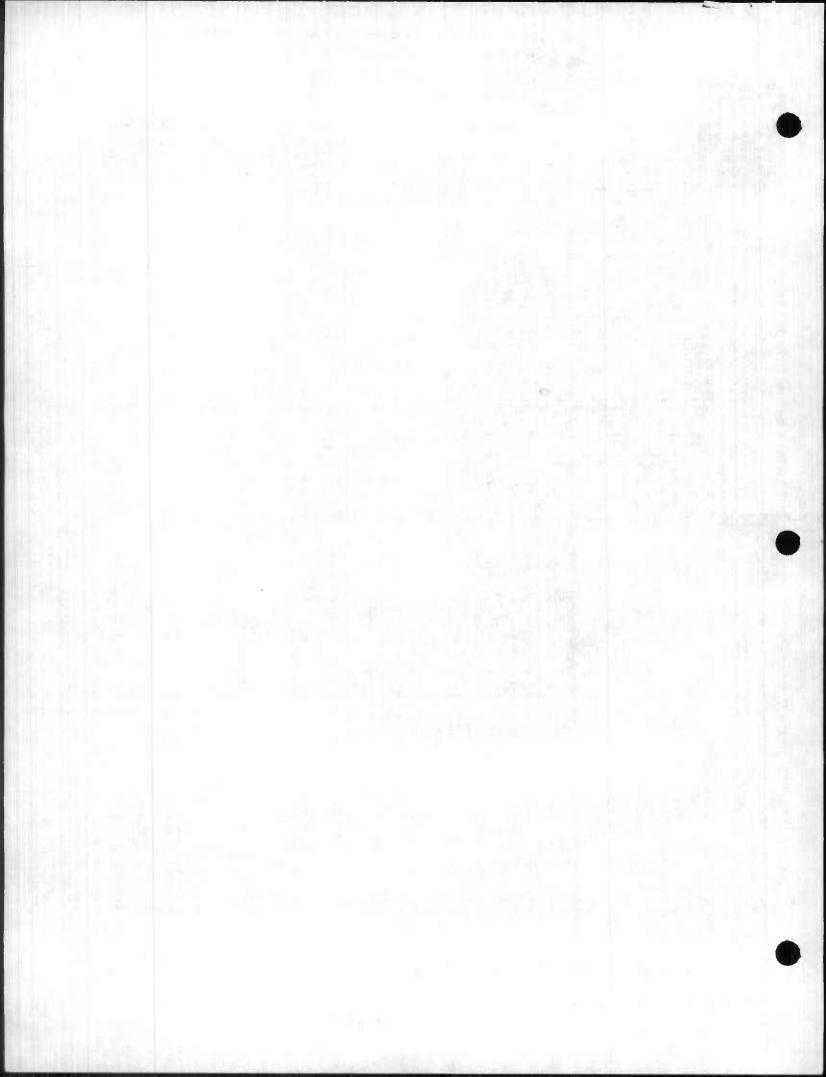
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State of Maryland / Department of Health and Mental Hygiene

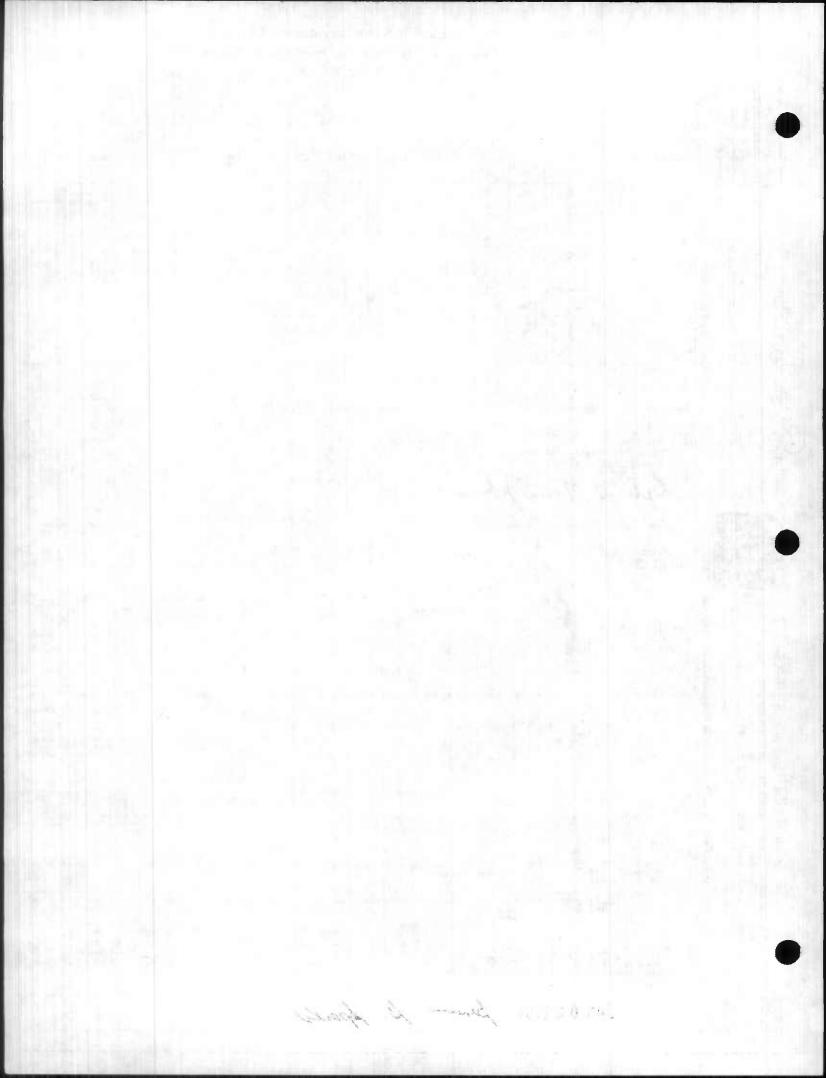
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4	Physician /Medical	Joseph M. Enf	ante							Dec.	21, 20		7:35	P.M.
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	To the Hospital or Attending Ph within 24 hours after death.  De the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a, Certifier Certifying	Physician: To the b	est of my knowled	ice, dest	h occurred	at the tir	ne, date ar	d place	and due to the o	ause(s) and a	nanner es e	stated	
	To the Hospital within 24 hours of the Funeral completely filled	(Check only one) 2 Medical Ex	caminer: On the bas	is of examination	and/or in	vestigation	in my o	pinion, dea	ith occur	red at the time, d	ate and place	, and due t	o the cause(	5)
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State of Maryland / Department of Health and Mental Hygiene

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Funeral Director	5. Social Security Number 6. Social Security Number 11 Usual Residence of Decedent	2 Age (In 7. Age (In	vrs. lest birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min,	8. Date of Bir (Month, Da MARCH	31,1927 V	9. Birthplace Country VASHING	(State or Foreign GTON, DC
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di pa i	10e. Street and Number 5865 MASON SPRING	ROAD		10f. Zip Code 206	540		10g. Citizen of W UNITED		
020 urs after at', or the	11. Marital Status  1 □ Never Married 2 ☒ Merried  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1  Yes 2 No Il Yes, Give Year or Detes:	n U,S. 13.	Was Decedent of hilf Yes, specify Cub	lispanic Orlgin? (Span, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)	14. Raca Black Specify:	- American In c, White, etc.	
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Maryte d 2 should th and Mer th and Mer traumarte traumarte	19a. Informent's Name/Relationship (7	ype, Print)	19b. Mail	ling Address (Street	and Number or Run	al Route Numb	er, City or Town, S	State, Zip Cod	(e)
1 6205	MARGARET C. FOSTE	R / WIFE	5865	MASON SPI	RING ROAD,	INDIA	N HEAD, I	MARYLAN	ND 20640
Baltimore, Income, Income, Income, Income, Income, Income, Income, Income, Information of the Income,	20a. Method of Disposition	20	b. Place of Disp cemetery, cre	position (Neme of emetory or other ple	ce)	Date	20c. Location - 0	City or Town,	Stete
Baltimor pemir. Pages Department of Important: If it any injury or o	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		ET CEMETI		L/3/01	WASHING'	ION, D.	.C.
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Division of To the Hospital or Atlanding Ph. within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury building, etc. (Sc	At home, lerm, s ecify)				Street end Numbe wn, Stete)	er or Rurel Ro	ute Number,
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	30. Name end address of person who c			e, Print)	-0046419	27		8/00	
	Charlene A. Leto			Charles	St. Lal	lata,	MD 20646		
State Registrar	31. Date filed (Month, Day, Near) 2	2001 32. Registar's S	1	J. Spa	the				

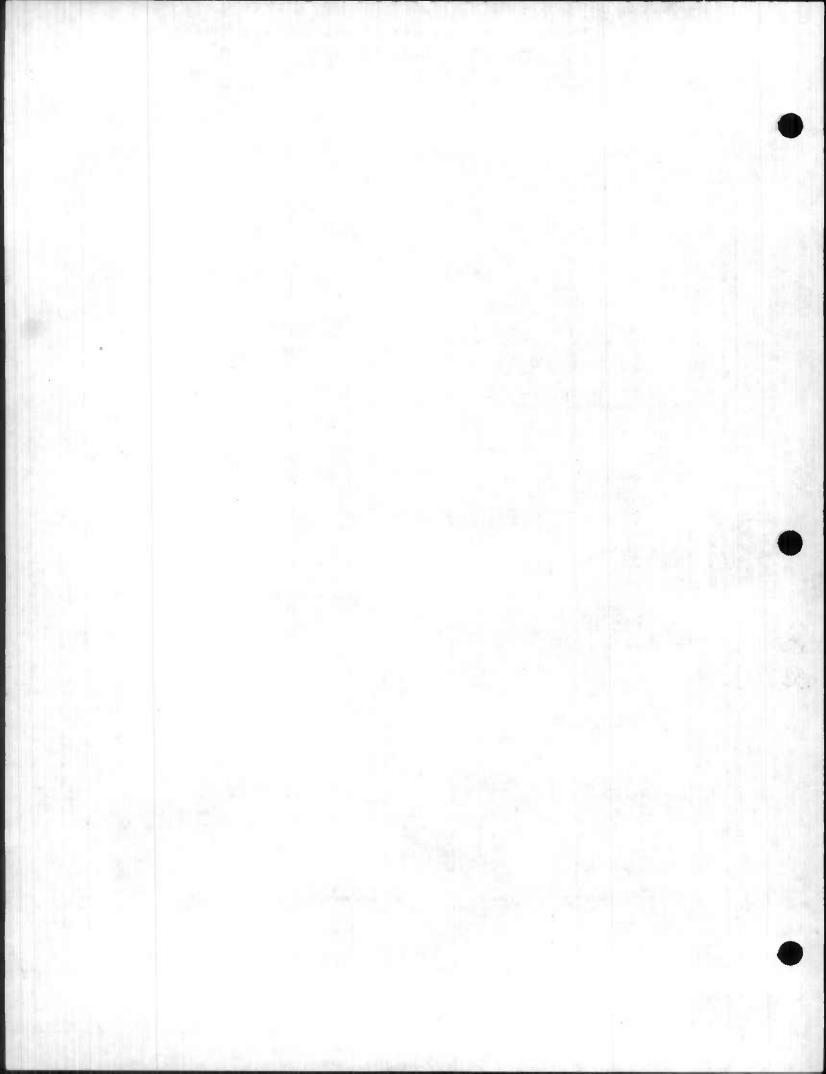


#### Please Type or Print in Black Indelibie ink. Assure Aii Copies Are Legibie.

AMEND TIEM:	23 PART I PER HHY G791 1-1121	2000 WR yland /	Certificate of	Death		g. No.	42	956				
Physician	Decedent's Nama (First, Middla, Last)				2. Date of Death Month	Day	Year	3. Tima of Deeth				
Physician /Medical	John Freeman				11		2000	10:10 Pm				
Examiner	4e Facility Name (If not institution, giva street an	d number)		4b. City, Town, or Lo	cation of Death	4c. County	of Death					
	University of Maryle		System	Baltimore								
Funeral	5. Sociel Security Number 6. Sax	7. Aga (In yrs. last b	irthday) if Under 1 Yea  Months Dey		8. Deta of Birth (Month, Day,	Year)	Country					
Director	215-26-4395 Usual Rasidence of Decedant	88	113.		June 30	,1912	Maryl	and				
ž	10a. Steta 10b. County	10c. City, To	wn or Location				100	1. Inside City Limits				
28a-1 show notified at rector								1⊠Yes 2□No				
Director	Maryland Talbot  10e. Street and Number	La	Ston 10f. Zip Coda		10	g. Citizen of W	hat Country	y?				
	22 South Locust Stree	r	2160		15.5	USA						
Funeral	11. Marital Status 12. Was	Decedant Evar in U.S.		Hispanic Origin? (Spe ban, Maxican, Puarto	city Yas or No-	14. Rece	- Amaricar					
	1 Navar Married 2 Married 1 🕱	d Forcas? ′as 2 □ No			Rican, atc.)		c, White, at	c.				
by	3 Widowad 4 Divorced Yaar	s, Giva or Datas:	1 ☐ Yas 2 🛣 No	э эресну:		Specify:	Blac	k				
Completed	15. Decedant's Education (Specify only highast grada compla	ted) 166	a. Decedant's Usual Occi (Giva kind of work don	a during most of worki	na 1	6b. Kind of Bu	siness/Indu	stry				
jdu	Elementary/Secondary (0-12) Cottle	ge (1-4or 5+)	lita. DO NOT use retir	ed)								
	7		Janitor	40.44-4-4-31	(Fine Adiable Ad	Offic						
Be	17. Fathar's Nama (First, Middle, Last)			18. Mothar's Nama			1)					
5	Clarence Freeman			Lottie		bson	O 7:- 0	N. 4-1				
	19a. Informant's Name/Ralationship (Type, Print,		b. Mailing Addrass (Strat									
	Deborah Watkins / da 20a. Method of Disposition	-0	611 E. Dover	Street, E.		Oc. Location - 0						
	1 ■ Burial 2 □ Cramation 3 □ Removal f	rom Stata cemat	ary, cramatory or other p	1								
	4 Donation 5 Other (Specify)	Mary1			1/27/200	0 Beul	Lah, Ma	aryland				
DUCE	4 Donation 5 Other (Specify)  21. Signatura of Function Service Uceasee    Maryland Veterans Cem.   11/27/2000 Beulah, Maryland   22. Nama and Addrass of Facility   Bennie Smith Funeral Home   426 Dover Street, Easton, Maryland 21601											
	©3a. Pent1. Enter tha disaasa, or complications t shock, or haart failura. List only ona causa							01 Approximate				
cal Examiner	Immediata Causa (Final disaasa or condition resulting in daath)  Sequentially list conditions, if eny, leeding to immediata causa. Entar Underlying Cause, (Disaese or Injury C.	Respirate	)	mia								
by Physician/Medical	Cause (Disaess or Injury thet initiated events rasulting in death) Last	Dua fo (or es e	consequence of):									
/sician/Me	Part It. Other significant conditions contributing	to death but not resulting	In the underlying causa	given in Part I.	23b. Did tob	acco use con	tribute to t	he cause of death?				
Ph	Altered MENTAL	CTATUS			1 □ Ye	2 2 No	3 Probe	bly 4 Unknown				
d by	1 1112:52 1 01 - 110				24a. Was an	autoney	24h War	e eutopsy findings				
Completed	La Trial Table 1 (PALE)				perform	ed?	com	lable prior to pletion of cause seth?				
du												
ပိ					1 ☐ Yas	1-	1	Yas 200 No				
Be	25. Was casa rafarred to medical examinar? Hospital:	.m/		26. Place of Death			(0					
- To		1 Nnpatiant 2 ER/C Data of Injury Month, Day Year) 28b.	Time of trijury 28c. In	4 Li Nuising Ho	me 5 Rasider 28d. Dascribe how		-					
tlo	1 Natural 5 Panding (	Month, Day Year)		ork? □Yas 2□No								
ffce	3 Suicide 6 Could not be 28a. F	Place of Injury - At homa,	farm, street, factory, offic	а :	28f. Location (Str.		er or Rural	Routa Number,				
- La	4 Homicida detarrirred	ouitding, atc. (Specify)		100	City or Town,	Stete)						
edical Certification:	29a. Cartifiar (Check only one)  15 Certifying Physician: To the control on the c											
Medical Certifi	29b. Signatura and titla of certifiar	E FEATURE	29c. Lice	nse number	29	d. Data signed	(Month, D	ay, Year)				
	Harley O A	IEma N	1.0.	439	- 10	11 - 2	C1 - A -					
	30. Nama and address of person who completed			, 51		11-2						
	Humphrey O. Atiemo	· University		rykind. B	alt, more	Mary	land.					
State	31. Data filed (Month, Day, Year)	32. Registrar's Signatura	G. Sport	11	7	,						
gistrar	NOW 2 7 2000	32. Hegistrar's Signatura	N. MOBUL	2								

**ORIGINAL** 

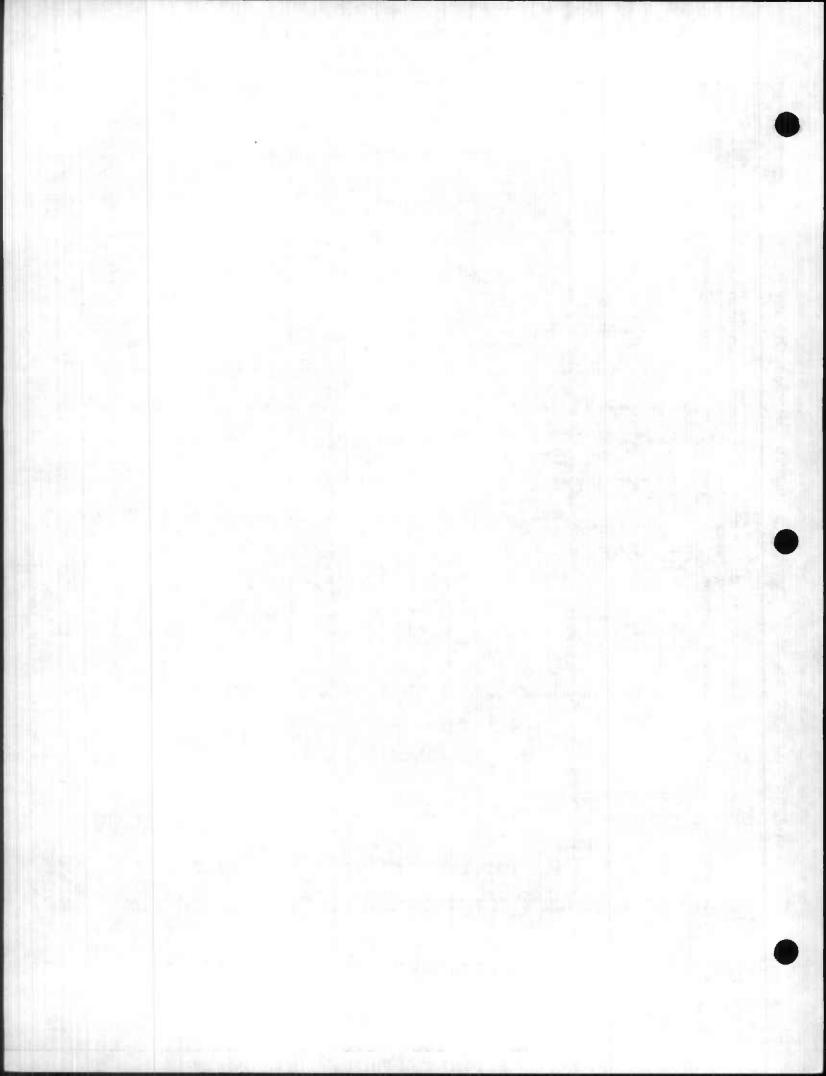
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State of Maryland / Department of Health and Mental Hygiene 1 4 2 9 5 7

					Certi	ficate of	f Death			Reg. No.	I be	
п	Dhusisian	1. Decedent's Name (First, Middle,	Last)	100000	0.0			75	2. Dete of De	eth	Yeer	3. Time of Death
	Physician /Medical	SI	nirley Ann	e Holcomb					Decemb	er 25, 2	2000	1004
H	Examiner	4a Facility Neme (If not institution,	give street and num	oer)	104		4b. City, To	own, or Lo	ocation of Deat	h 4c. County	of Death	
		Union Hospit	al of Cec	il County	,		E	1kto	n		Ceci	1
	Funeral			. Age (In yrs. last bii		If Under 1 Yes		24 Hrs. Min.	8. Date of Bid (Month, Da	th	9. Birthp	lace (State or Foreign
	Director	212-38-2154	1□M 2\\ F	63	Yrs.				Sept.	20,1937	Nort	h Carolina
	b .	Usual Residence of Decedent  10a, State 10b, County		40a City Tow		tion.						Od Incide Oit I bein
	ahova ahov			10c. City, Tow	m or Locat		D				·	0d. Inside City Limits 1 ☐ Yes 2 ☒ No
	Ser A	Maryland (	Cecil				Depo	sit				
	vith the Me t or 28s-f a be rectified	10e. Street and Number				10f. Zip Code		,		10g. Citizen of V		ntry?
	after death with the Marylan or Items 23s or 28s-f show inches must be rediffed at y Funeral Director	281 Adams Road				5 7 5 1	2190				S.A.	
	ifter death or thems 234	11. Merital Status	Armed Ford		13. Wa	is Decedent of es, specify Cu	Hispanic Or Iben, Mexica	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	- 14. Raci Blac	a - Americ k, White,	
8	72 hours after death with the Maryland natural; or Items 23s or 28s-f show use Examinar must be redified at eted by Funeral Director	1 Never Married 20 Marrie	If Yes, Give		10	Yes XX N	o Specify	:		Specify	: W	hite
8	"natural",	3 Widowed 4 Divorced	Year or Dat		D 4					40h 10h 4 - 4 P		
15	ed within 72 ho ygiene. er then "netura ft, the transcal Completed	15. Decedent's (Specify only highest	grade completed)	168	(Give kin	nt's Usual Occ and of work don NOT use reti	upation e during mos	st of work	ing	16b. Kind of Bu	siness/inc	dustry
12	within ene.	Elementary/Secondary (0-12) Twelve Years	College (1-	for 5+)	11/6. DO	Homema				Person	121 R	esidence
d 2			nst)			Homenic		er's Nam	e (First, Middle	, Maiden Sumam		esidence
an	B SEE		ert V. Sex	ton						Miller		
2		19a. Informant's Name/Relationsh			Mailing	Address (Stre	et and Numb			er, City or Town,	State. Zic.	(Code)
Maryland 21215-0020	O1 00 00 00	Thomas E. Holcor								, Maryla		21904
	- 9 E E	20a. Method of Disposition		20b. Place o	f Dispositi	ion (Name of			Date	20c. Location -		own, State
n O	Pages nent of int: If the iry or o	12 Bunal 2 Cremetion				noham (		rv i	2/28/00	Colora	Ma	ryland
Baltimore,	permit. Pag Department Important: I any injury o	4 Donation 5 Other (Sp. 21. Signeture of Funerel Service L				lame and Add			2,20,00	001010	,	Lyland
Ba	permit. Page Department of Important: If any injury or ance.	h / L			Lee	e A. Pa	atters	on &	Son Fu	neral Ho	me,	P.A.
-		Thomas In	1 alles	. 25 , Sat	Pe	rryvil	le, Ma	ryla	nd 219	03-0766		6 marie de la companya del companya de la companya del companya de la companya de
		23a. Part1. Enter the disease, or o shock, or heart failure. List of	nly one cause on ee	ch line.	not enter t	the mode of d	ying, such es	cardiac	or respiratory e	rrest,	1	Approximete Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Final	0	000							1	
4	Examiner	disease or condition resulting in death)	a. / :	SEVD								Months
	<b>a</b>		P	Due to (or as a	conseque	enca of):						Months
	executed n and latertransit Examiner		b. 972				675				<u> </u>	rioning
-6	al-tra	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a	conseque	enca of):					1	
68760,	sicial pur	Cause (Disease or injury that initiated events	c	Due to (or as a							-	
89	eath certificate be executed attending physician and for use as the burlet-transit claryMedical Examir	resulting in deeth) Last		Due to (or as a	consequer	nce oi).						
×	nding use a		d								-	
Bo	that the death cert ed by the attendin detached for use / Physician/N	Part II. Other significant condition	e contributing to doe	th but not requiring i	n the unde	othring parros	nium in Rod	1	23h Did	tobacco usa co	ntribute t	the cause of death?
0	t tha di by the tached	Part II. Other significant condition	s contributing to dea	in but not resulting i	II (IIO GITGO	enying cause :	given in ren	1.		Yes 2 No		bebly 4 Unknown
0										144 200140	0_110	
Vital Records,	een sign hould be									an autopsy		ere autopsy findings
00	been s should	BULL THE SECTION OF SE							pert	ormed?	co	ailable prior to impletion of cause death?
Re	The law require cate has been single 2 should Completed								40	Yes 2 PNo		☐Yes 2☐No
a	certificate rector, pag	25. Was case referred to medical		200			00.01-				11	
5		examiner?	Hospitel: 1 1	patient 2 ER/O	utnations	3 DOA	Whor		h (Check only	idenca 6 □Oth	or (Consi	6-1
o	5 5 5	27. Menner of Death	28a. Date of	Injury 28b.	Time of	28c. In		ursing ric		how injury occur		<u>y</u> )
Division	Attending Ph r death. ector: After th by the funeral	1 '☑Neturel 5 ☐ Pending 2 ☐ Accident investigs		Day Year)	Injury		/ork? □Yes 2□	No				
isi	death ctor: A y the f	3 ☐ Suicide 6 ☐ Could no	ed 286. Piece 0	f Injury - At home, fe	erm, street	I, fectory, offic	a			Street and Numb	er or Run	al Route Number,
á	tal or Attending P rs after death. al Director: After t led in by the funer: Certification:	4 Homicide	building	, etc. (Specify)					City or To	wn, State)		
	Hospital 24 hours Funeral stely filled dical C	29a. Certifier 1 Certifying	Physician: To the b	est of my knowledge	e, death oc	ccurred at the	time, date e	nd plece,	and due to the	ceuse(s) end ma	inner as s	itated.
	n 24 hound n 24 hound	(Check only 2 Medicai E	kaminer: On the bas and manne	is of examination an	nd/or inves	sligation, in my	opinion, de	ath occur	red et the time	dete and placa,	and due to	o the cause(s)
	To the Hospital or An within 24 hours after d To the Funeral Direct completely filled in by Medical Certifil	29b. Signeture and title of certifier				29c. Lice	nse number			29d. Date signe	d (Month,	Day, Year)
		1 Sach	Levs M	0		De	2332	22		12.	25.0	00
	5	30. Name and address of person w		of deeth (item 23a)	(Type, Pri	int)				-1,2	10.	
		S. S. SAMIN	EUMD,	118 N/m	ME 2	St Sui	6 3	13	Ell	izton M	021	921.
	State	31. Date filed (Month, Day, Year)	32. Re	pistrer's Signature	1			0 1	4			
	Registrar	DEC 2 7 2000	Severy	B.	200	rest						

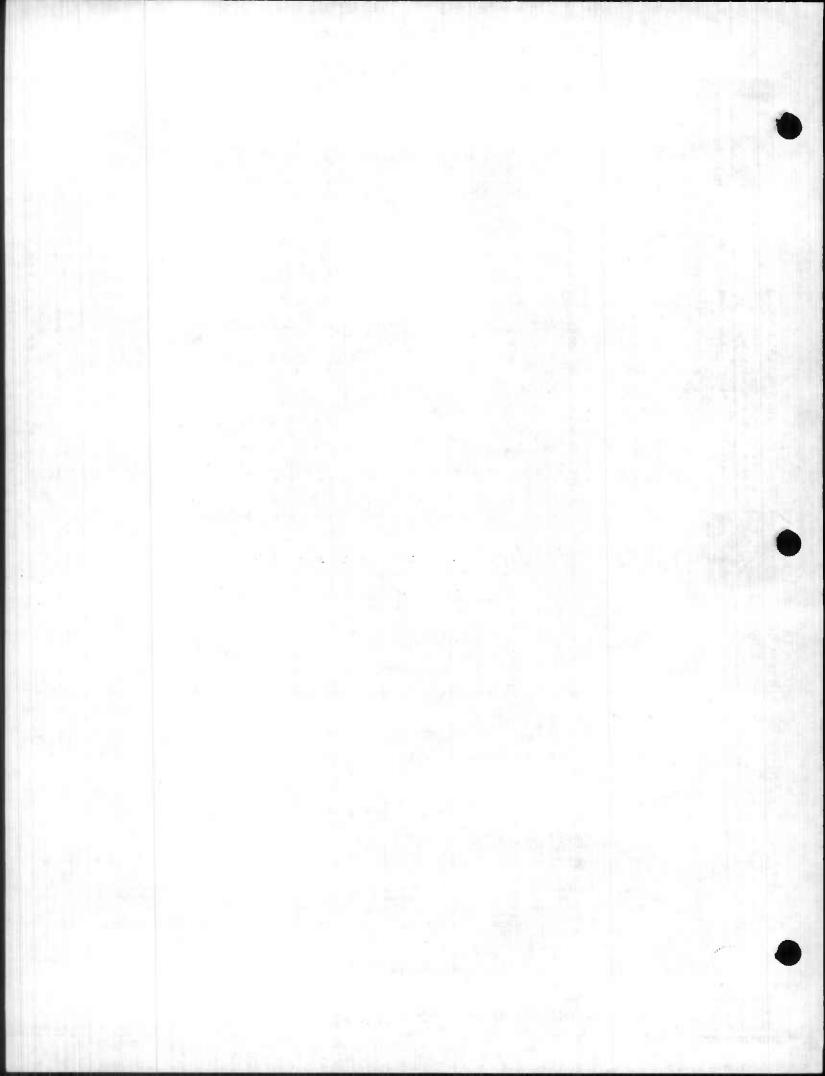


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				ertificate of		Ĭ	Reg. No.	42	958		
Physician	Decedent's Nama (First, Middla, Last					2. Data of De Month	Day	Yaar	3. Time of Death		
/Medical	June Gilroy I					Decembe	-		11:08 pm		
Examiner	4a Facility Nama (If not institution, giva				4b. City, Town, or L						
	Crofton Convales			If Under 1 Yaar	Crofton		Anne				
Funeral Director	3/8-24-08/3	M 2 F	n yrs. last birthde 75 Yrs.	Months Days	Hours Min.	8. Data of Bir (Month, Da Mar. 2	ly, Year)	9. Binnpi Count Mar	ace (State or Foreign try) Yland		
the Maryland 28a-f show sottlise at ector	Usual Rasidance of Decedant  10a. Stata  10b. County		Oc. City, Town or	Location				10	od. Inside City Limits		
or 28e-1 s be notified Director	Maryland Prince G	George's	Upp	per Marlbo	ro						
Die Dire	10e. Street and Number			10f. Zip Coda			10g. Citizen of W		try?		
and and and and and and and and and and	10110 Campus Way				.0772		U.S.A				
72 hours after death with the Manfar naturals, or thems 23e or 28e-f show lical Examines mount be notified at sted by Funeral Director	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedant Eve Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:	ar in U,S. 1	3. Was Decedant of H It Yas, specify Cub 1 ☐ Yas 2 ☒ No	an, Mexican, Puarto	Rican, atc.)	Black Specify:	- America k, Whita, a Whi	atc.		
P P P P P P P P P P P P P P P P P P P	15. Decedant's Edu	ication	16a. De	cedent's Usual Occup	pation	1	16b. Kind of Bu	sinass/Ind	lustry		
within sone than the Man	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		iva kind of work dona DO NOT usa retire at Wrapper		king	Giant	Food			
	17. Fathar's Nama (First, Middle, Last)				18. Mothar's Nam	a (First, Middle					
of 2 should be lies  2 should be lies  3 is marked other  To Be C	Charles Gilro	у			Grace	Woolwin	ne				
should Man and Man and Man and Man and Man and Man and And And And And And And And And And A	19a. tntormant's Name/Ralationship (T)		19b. Ma	ailing Address (Street	and Number or Ru	ra/ Routa Numb	er, City or Town,	Stata, Zip	Code)		
C T M L	Ronald L. Hall -	Son	631	4 61st Ave	nue, Rive	erdale,	MA 207	37			
of the district of the distric	20a. Mathod of Disposition		20b. Place of Dis	sposition (Nama of cramatory or other pla	ce)	Data	20c. Location -	City or To	wn, State		
Pages mining ry or o	1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			1 Memorial		1/02/01	Falls	Churc	h. VA		
permit. Pages 1 a Department of Hea Important: if Item any Injury or othe ansa.	21. Signature of Funeral Sarvice Licens			22. Name and Addra Gasch's Fu	ss of Facility neral Hor	ne, P.A.					
	allen An	and the same		4739 Balti		- 3		e, MI	20781 Approximata		
Physician	23a. Partī. Entar tha disaasa, ŏr compi shock, or haart tailura. List only o	na causa on aach lina.	a daatri. Do not	antar tha moda ot cyn	ig, such as condiac	or raspiratory a	mast,	1 1 1	Intarval Between Onsat and Death		
/Medical Examiner	Immediata Ceusa (Final disaasa or condition rasulting in death)  Atherosclerotic Cardiovascular Disease										
- in			ie to (or as a con								
nsit ted		D		ctive Lung	Disease			Y	ears		
physicien and site burial-transit	Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or injury	Du	a to (or as a con-	sequance of):							
70 FD 61	rasulting in daath) Last		a to (or as a cons	sequance of):							
attendin for use		d									
. 0 00	Part II. Other eignificant conditions con	ntributing to death but r	not resulting in the	a undarlying cause give	ven in Part I.	23b. Dtd	tobacco use con	tribute to	the cause of death?		
requires that the death certifies are signed by the attending hould be deteched for use after by Physician/M	Lung Tumor					10	Y●● 2 No	3 Prot	bably 4 Unknown		
been should							an autopsy ormed?	ava	ara autopsy tindings ailabla prior to mplation of cause death?		
						10	Yas 2 🗓 No	10	Yas 2□ No		
yaician: The law is certificate hes director, page 2	25. Was casa reterred to medical				26. Place of Dea	th (Check only	ona)				
Physical this certail direction To E	axaminar? 1 ☐ Yas 2 ☒ No	Hospital: 1 ☐ Inpatiant	2 ER/Outpa	tient 3 DOA Oth	ner: 4 🔀 Nursing H	oma 5 Rasi	idance 6 Othe	ar (Specify	v)		
Attending Physician: otdesth. by the funeral director, iffication: To Be (	27. Manner of Death 1 ☑ Naturat 5 ☐ Pending 2 ☐ Accident invastigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Time	y Wo	ry at rk? Yas 2 □ No	28d. Describe	how injury occurr	ed			
To the Hospital or Attending Physician: 1 within 24 hours eiter deeth. To the Funeral Director: After this certifical completely filled in by the funeral director. Pedical Certification: To Be C	3 Suicida 6 Could not be 4 Homicida datamined	28a. Place of Injury building, atc. (	At homa, farm, (Specify)	streat, factory, office		28t. Location ( City or To	(Street and Number wn, State)	er or Rura	l Routa Number,		
ne Hospita n 24 hours ne Funeral pletely fille	29a. Certifier 1 Certifying Physical Control Check only 2 Medical Examination	sician: To the best of ner: On the basis of ex and manner stated	amination and/or	eath occurred at the til r investigation, in my o	me, date and place, opinion, death occur	and dua to tha red at the tima,	causa(s) and ma date and place, a	nnar as si and due to	ated. tha causa(s)		
within o the omple	29b. Signatura and title of certifiar			29c. Licens	sa number		29d. Data signed	d (Month,	Day, Year)		
- 5 - 0		h ano	101.	D20	108		December	28,	2000		
(10)	30. Nama and addrass of person who co Rakesh Arora, M.D	ompleted causa of deat	th (Itam 23a) (Typ	pe, Print)		ie MD	20715				
1	31. Data tiled (Month, Day, Year)			ox Lane, #	ZZZ, DOW	Le, PID	20/13				
State Registrar	DEC 2 9 2000	32. Registrar's	Orginatura 4	Son Val							

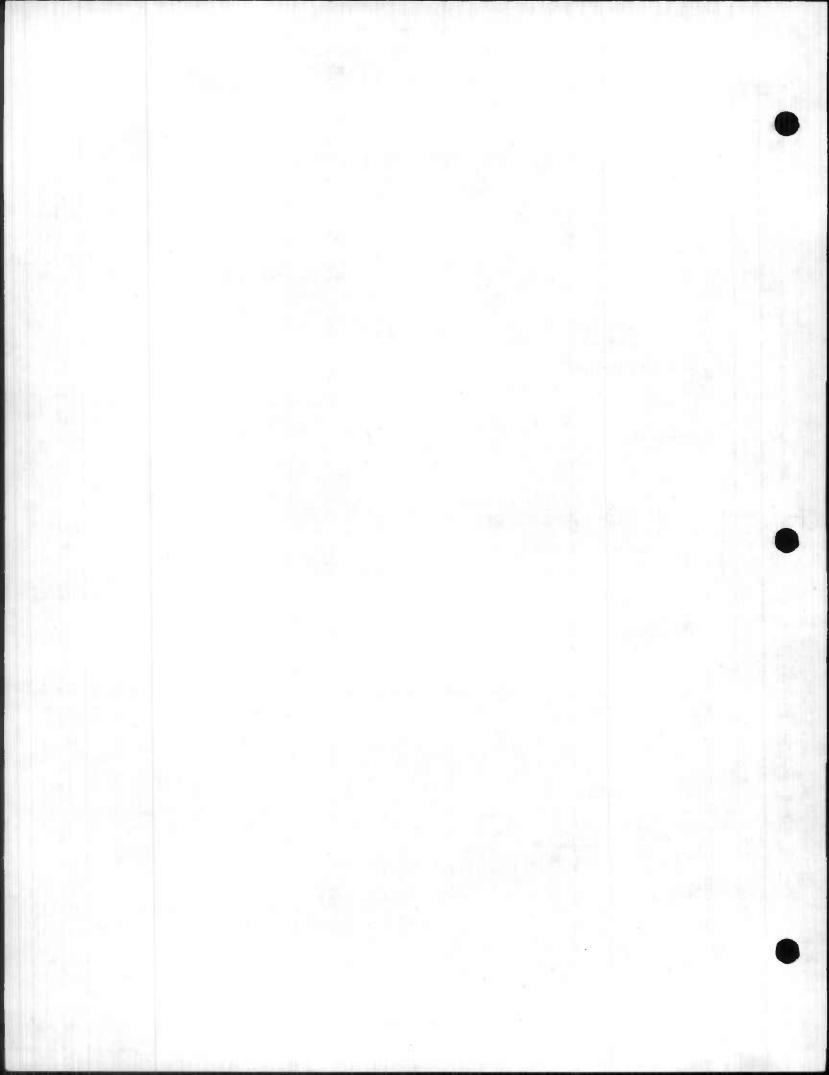
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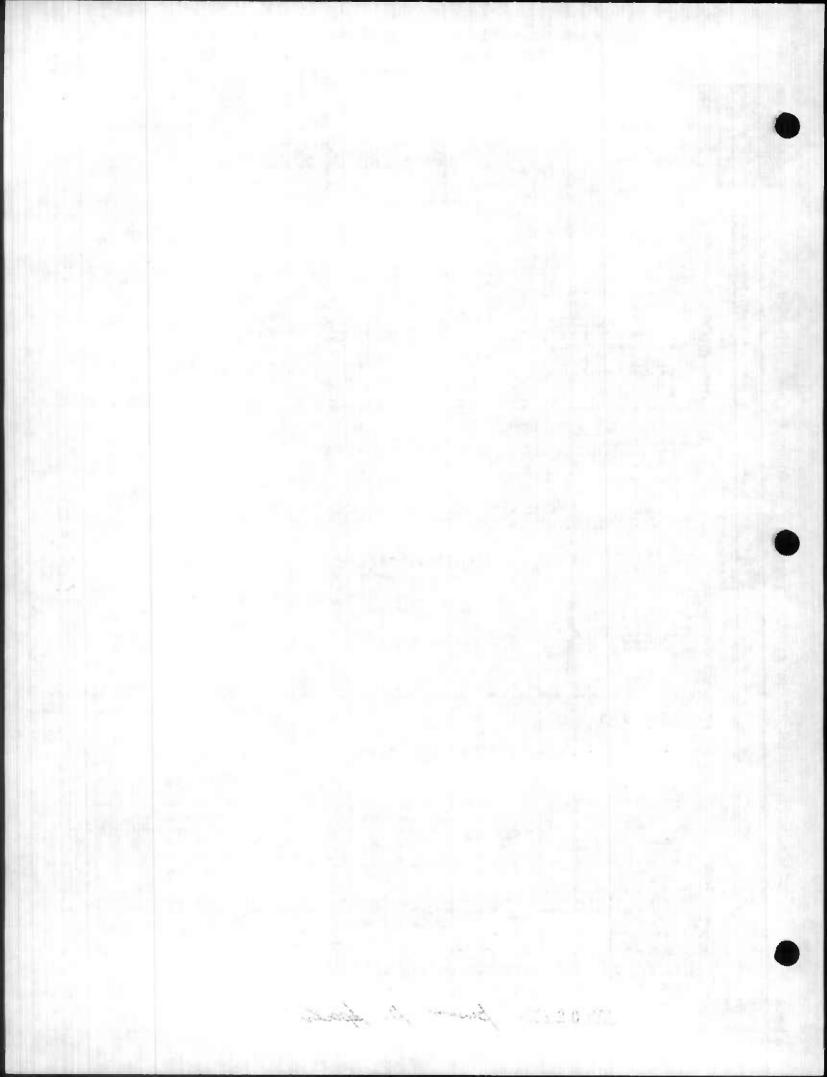
226-30-5263  100. State   100. County   100. City, Town or Location   100. State   100. State   100. County   100. City, Town or Location   100. State   100. State   100. County   100. City, Town or Location   100. State   100. State   100. County   100. City, Town or Location   100. State   100. City, Town or Location   100. State   100. City, Town or Location	ce (State or Foreign nia  I. Inside City Limits TYPes 2 No  17  Indian, c. ck  stry  rsity
EDYTHE C. IRVINE    Second Security Number   As Facility Name (if not institution, give street and number)   As Facility Name (if not institution, give street and number)   As Cally, Town, or Location of Death   Ac County of Death   As Cally, Town, or Location of Death   As Cally, Town, or Location of Death   As Cally, Town, or Location of Death   As Cally, Town, or Location   As Cally, Town or Location   As Cally, Tow	ges ce (State or Foreign nia Linside City Limits TY Yes 2 No  1 Indian, c. ck stry rsity
The color of the c	ges ce (State or Foreign nia Linside City Limits TY Yes 2 No  1 Indian, c. ck stry rsity
Social Security Number   Social Security Num	ce (State or Foreign nia  I. Inside City Limits TYPes 2 No  17  Indian, c. ck  stry  rsity
S. Social Security Number   S. Sex   1 m 2 kg   F   7. Age (in yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   S. Dete of Birth (Count (Count (Month), Day; Year)   Days   Months	ce (State or Foreign nia  I. Inside City Limits TYPes 2 No  17  Indian, c. ck  stry  rsity
Director    226-30-5263   13.   13.   14.   14.   1927   10.	nia  I Inside City Limits  IX Yes 2 No  IX Yes 2 No  Ck  stry  rsity
10a. State   10b. County   Maryland   Prince Georges   10c. City, Town or Location   Mt. Rainier   10c. Street and Number   3001 Queens Chapel Rd. #114   20712   U.S.A.   11. Marital Status   12. Was Decodent Ever in U.S.   13. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent Ever in U.S.   13. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent Ever in U.S.   13. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent Ever in U.S.   13. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Yes or No-Nitrie, et al.   12. Was Decodent of Hispanic Origin? (Specify Y	Yes 2 No  No  No  No  No  No  No  No  No  No
Elementary/Secondary (0-12)   College (1-4or 5+)   Custodian   Howard University of the content	Yes 2 No  No  No  No  No  No  No  No  No  No
Elementary/Secondary (0-12)   College (1-4or 5+)   Custodian   Howard University of the proper	ck stry rsity
Elementary/Secondary (0-12)   College (1-4or 5+)   Custodian   Howard University of the proper	ck stry rsity
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Elementary/Secondary (0-12)   College (1-4or 5+)   Custodian   Howard University of the proper	rsity
17. Father's Name (First, Middle, Last)  William H. Thompson  19a. Informant's Name/Relationship (Type, Print)  Chester L. Toliver- Nephew  20a. Method of Disposition  1 Germeton 3 Germeton 3 Germoval from State  4 Gonation 5 Gother (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Marshall's Funeral Home, Inc.  4217 9th Street N.W. Washington, DC  23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the disease of the cause on each line.	ode)
17. Father's Name (First, Middle, Last)  William H. Thompson  19a. Informant's Name/Relationship (Type, Print)  Chester L. Toliver— Nephew  20a. Method of Disposition  1	ode)
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23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line.	
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23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line.	
Physician	20011 oproximate
Immediate Cause (Final disease or condition resulting in death)     Atherosclerotic Heart Disease   Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
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1 Yes 2 No 1 State of Death (Check only one)  25. Was case referred to medical examiner?  1 Yes 2 No 1 State of Death (Check only one)  1 Yes 2 No 1 State of Death (Check only one)  1 Yes 2 No No 1 State of Death (Check only one)	
La patient 2 LER/Outpatient 3 LI DOA LA 4 LI Nursing Home 54 Residence 6 Li Other (Specify)	
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27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury 4 Home, farm, street, factory, office 3 Suicide 4 Homicide 29a. Certifier (Check only 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29a. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. Signature and title of certifier 29d. Date signed (Month, Day 29d. Date signed (Month) (Mon	ed. he cause(s)
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State of Maryland / Department of Health and Mental Hygiene 00 42960

				Ce	rtificate	of i	Death		R	leg. No.	8	200	U
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	and w	10a. Stata 10b. County		10c. City, Town or L	ocation						1	Od. Inside City	Limits
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/a		Guy Z. Johnson						Rosi	e Hamm	ett			
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	and alth m 27 i	Jill A. Johnson/	Daughter	1493	O Poto	mac	Rive	r Dr	. Cobb	Island,	MD 2	20625	
ore.	-195	20a. Method of Disposition		20b. Place of Disp	osition (Nema	a of her-place	ce)		Data	20c. Location -	City or To	own, Stata	
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	be axecute iclen end buriel-trans al Exam	Sequantially list conditions,		due to (or es a conse	equence of):								
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	the att	Part II. Other significant conditions co	entributing to death but	not resulting in the	underlying ce	usa giv	an in Part	1.	23b. Did to	obacco use co	ntribute t	o the cause o	f death?
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		30. Nama and addrass of person who d	complated ceusa of da	ath (Item 23a) (Type	, Print)	GY	AN.	C.	SURY	7NA			
		5851- Deals	church	yton 1	Road	-11	Den	10	SURI	20	75	1	
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** 12:13 P.M. AGATHA 17,2000 DEC. /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** PRINCE GEORGE'S HOSPITAL CENTER PRINCE GEORGE CHEVERLY MARYLAND If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** 1 M 2 DEF Yrs. Director 225-16-6653 87 Nov. 19,1913 Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1. Yes 2 No Maryland MITCH ELLVILLE MD. 28a-f Directo Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 'natural', or itsma 23a or must be 1003 ARBOR PARK PLACE 20721 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Stetus Bleck, White, etc. 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à AFROAMERICAN 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. other than Elementery/Secondery (0-12) Cottege (1-4or 5+) 9 HOME MAKER NONE permit. Pages 1 and 2 should be fin Department of Health and Mental Hy Important: If Nem 27 is marked oths any injury or other traumatic event 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Claude Thomas Robertson Nannie Fowkles 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUSSELL JACKSON / Son 3636 16TH. STREET N.W. WASHINGTON D.C. 20010 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete (4 □ Donatten 5 □ Other (Specify) 12/23/00FARNHAM VIRGINIA MT.ZION BAPTIST CHURCH 21. Signature of Funeral Service License 22. Name end Address of Facility BERRY O. WADDY P.O.BOX 305 LANCASTER VA. 22503 23a. Pat 1. Enter the disease, or complications that caused the dear shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Death Do not enter the mode of dying, such as cardiec or respiretory errest, **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ONAN that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760. Physician/Medical Due to (or es e consequenca of): 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? been si 24a. Wes en eutopsy performed? Completed page 2 2 7 No 1 ☐ Yes 2 ☐ No of Vitai 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ENOutpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Injury et Work? Division or Attanding 1 DNatural 5 Pending investigation s after dea. 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide • Funeral Dira letely filled in b Hospital Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) To the I within 2 29b. Signature and title of certifie 29c. License numbe 29d. Dete signed (Month, Day, Year) LOKEDON 30. Name end eddress of person who completed cause of death (ttem 23a) (Type, Print) Wendell Pierson MD Prince George's Hospital 3001 Hospital Dr., Cheverly Md. 20785

**DHMH 16 Rev 6/95** 

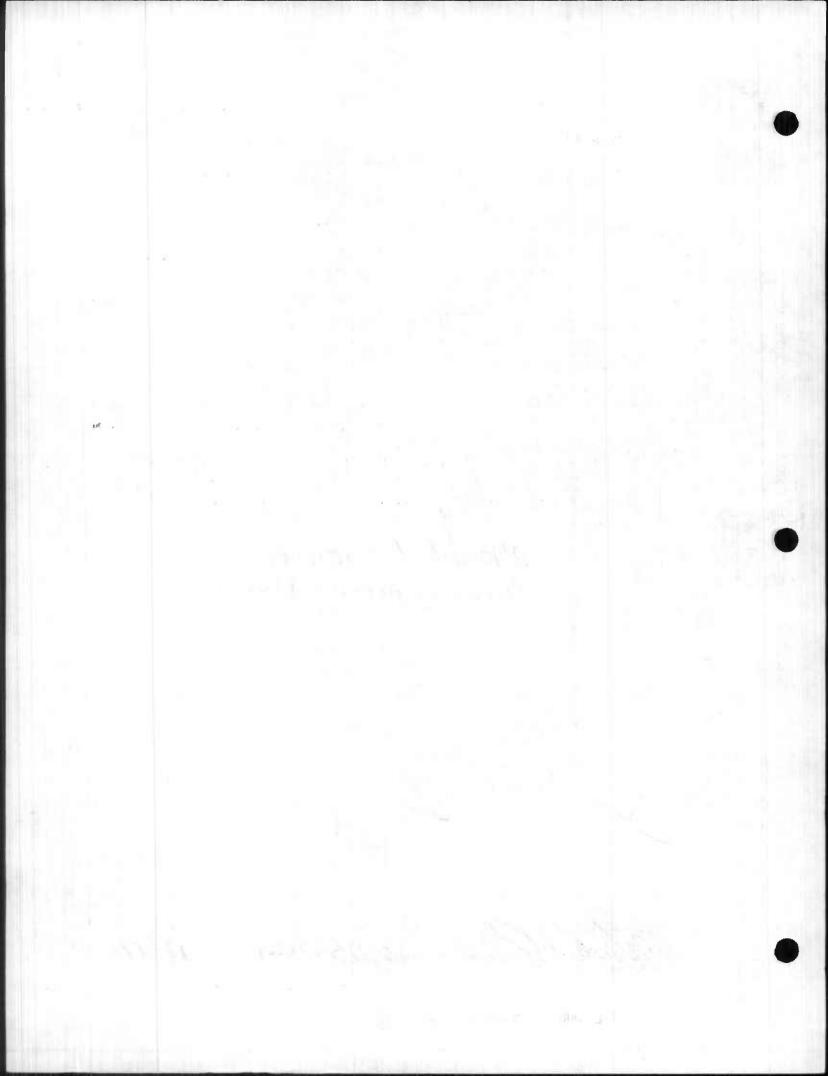
State

Registrar

31. Dete filed (Month, Dey, Year)

DEC 2 2 2000

32. Registrer's Signature



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death Month Yaer Dec 1301 JOHNSON 2000 L. ATTICIA 23 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Nama (If not institution, giva street and number) HNNAPOLIS If Under 24 Hrs. 8. Dete of Bir Arundel Coen. HOSPITAL 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Say 1 M SESKF Months Days Hours Yrs. 220 60 4981 Jan. 30,1953 Maryland Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Insida Cltv Limits 1 Yas 2 No Maryland Anne Arundel Davidsonville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3736 Patuxent Manor Rd. 21035 United States 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Btack, White, etc. 1 Yas 2 No If Yes, Giva Yaar or Dates: 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade complated) Etementary/Secondary (0-12) Collega (1-4or 5+) 12 Homemaker Own Home 18. Mothar's Neme (First, Middla, Maidan Sumama) 17. Father's Name (First, Middle, Last) James B. Handy Gladys LeCompte Husband 19b. Mailing Addrass (Street and Number or Rural Routa Numbar, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) James Michael Johnson, Sr. 3736 Patuxent Manor Rd. Davidsonville MD 21035 20b. Place of Disposition (Nama of cematery, cramatory or other place) Dec. 29, Date 000 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramovat from State 4 ☐ Donation 5 ☐ Other (Spacify) Lakemont Memorial Gardens Davidsonville MD 21. Signature of Funaral Sarvice Licensee 22. Nama and Address of Facility Robert E. Evans Funeral Home, Inc. 23a. Part1. Inter the disease, or complications that ceused the death. Do not anter the mode of dying, such es cardiac or respiratory arrast, Appreciations. List only one cause on each line. Approximata Interval Betwaen Onsat and Death Immediate Cause (Final disaesa or condition resulting in death) SeIZURE MINUTES Isorder elerium Iremens Hours Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Ceuse (Diseesa or injury that initiated avants rasulting in daath) Last Due to (or as a consequence of): 1cohol13m Chronic Dua to (or es e consequen Part II. Other algorificant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vnknown 24b. Wara autopsy findings eveilebla prior to 24e. Wes en eutopsy performad? complation of ceuse of death?

Physician /Medical Examiner

**Physician** 

/Medical

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**Funeral** 

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Maryland 21215-0020

Baltimore,

7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "

other t

ò any Injury

Examiner ician and buriel-tran physician a Physician/Medical 88 use signed by the a Completed page 2 certificate Be To this Certification:

P

P.O. Box 68760 or Attending Physician: funeral director, efter death. Hospital 24 hours

Division of Vital Records,

To the Vithin 2

Registrar

edical

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1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated.

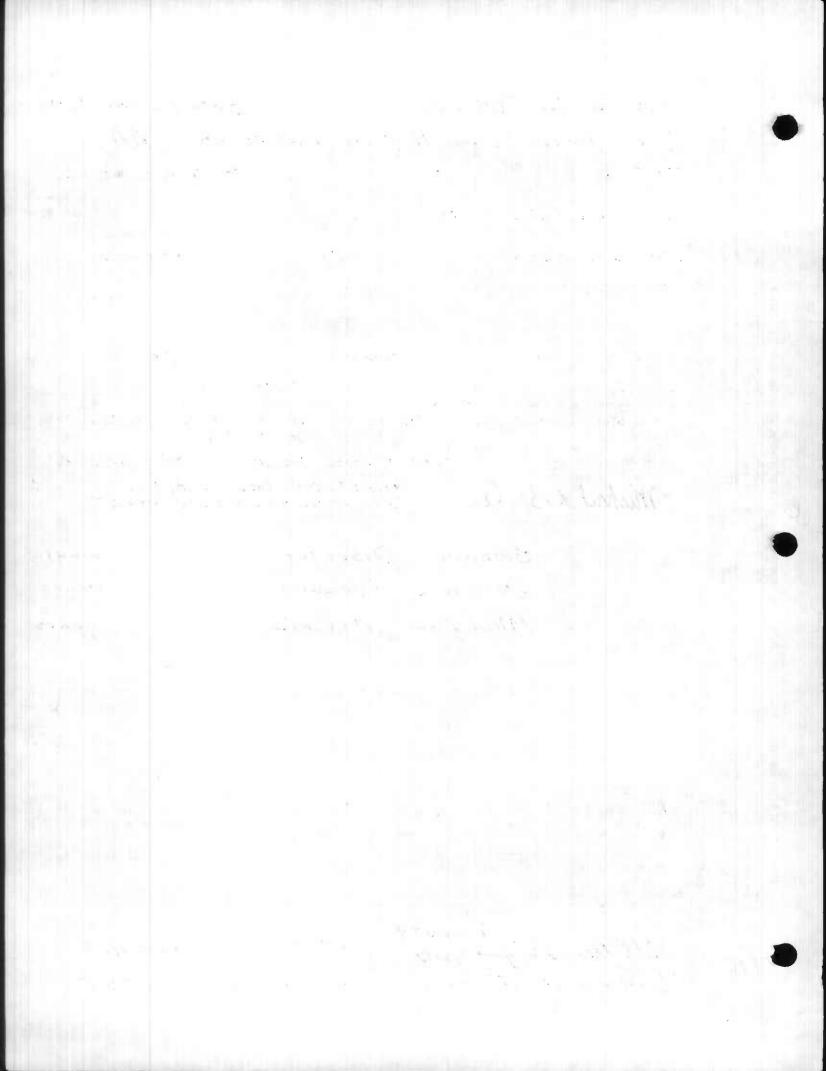
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29e. Cartifiar (Check only one)

29b. Signetyra end title of certifiar Deputy

29d. Data signed (Month, Day, Year)

ess of person who complated causa of daath (Itam 23a) (Typa, Print)

695 America 21035 ONES, mD 37. Registrar's Signature



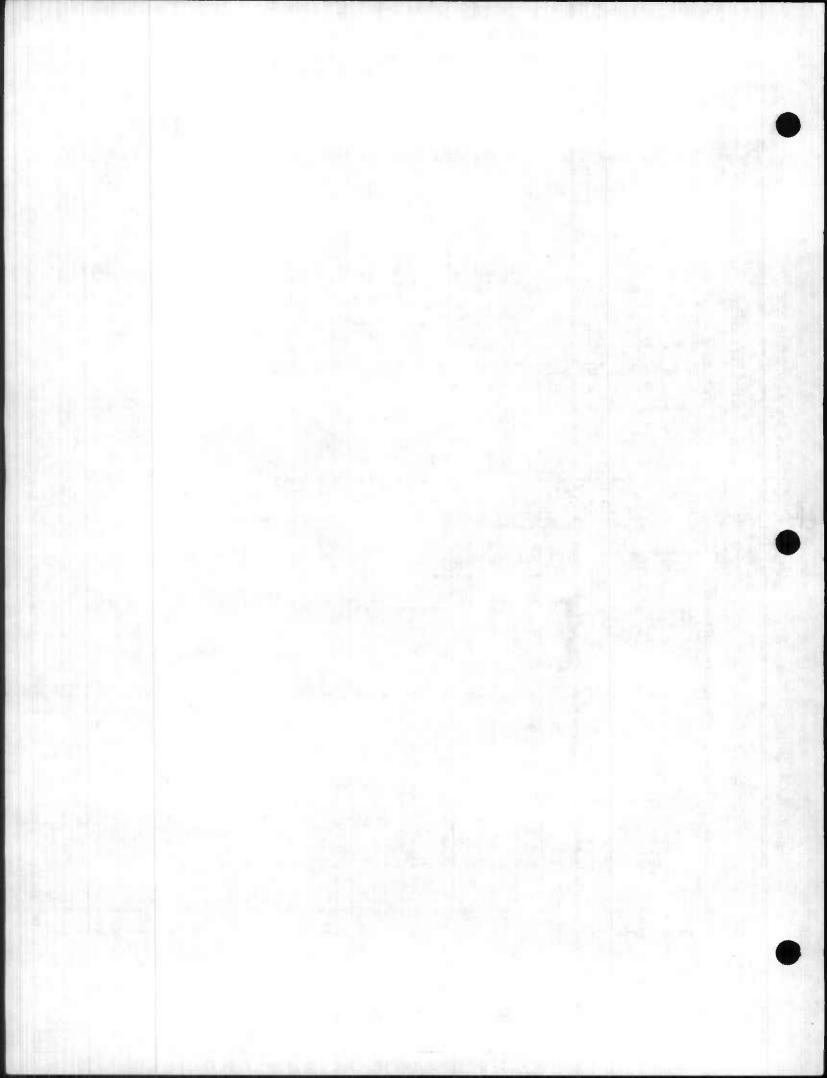
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Rea No. 0 0 4 2 9 6 3

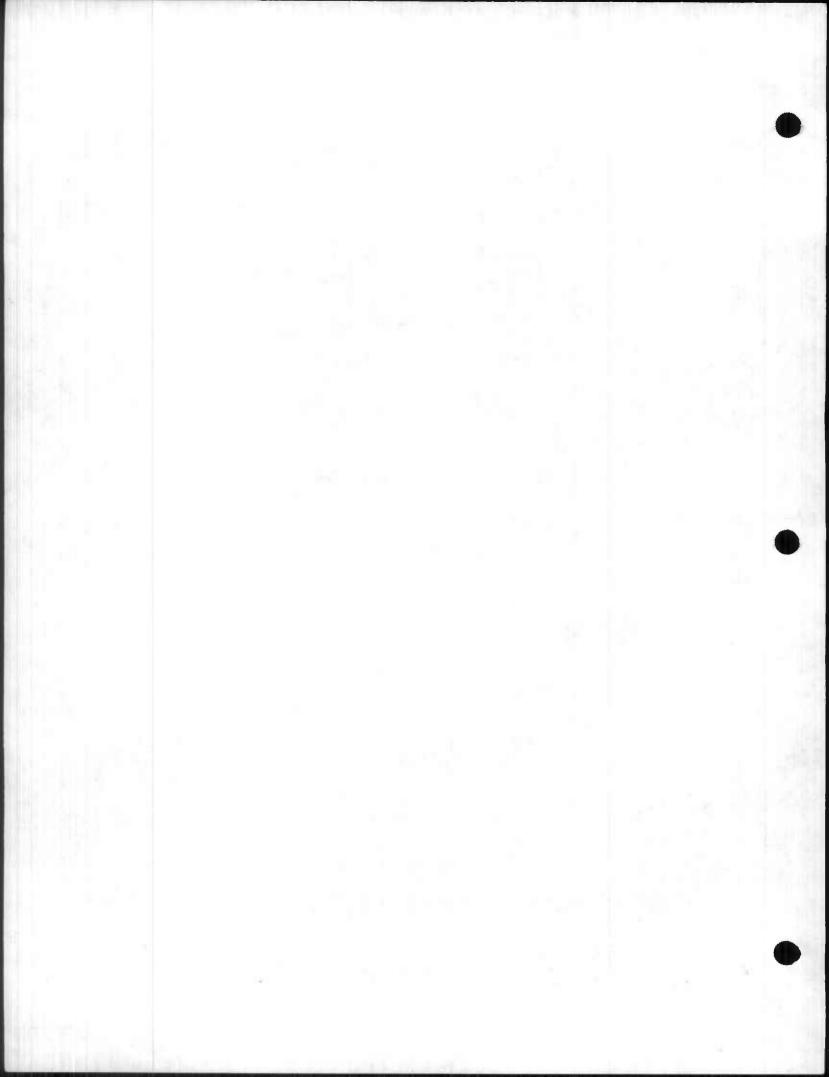
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Physician /Medical	John L. Jones J.	c .			Dec	24 2	000	4.031
Examiner	4a Facility Nama (If not institution, giva street and nur Union Memorial Hos			Balti			of Death	17.0
<ul><li>Funeral Director</li></ul>	5. Social Security Number 238-64-8143 6. Sex 124 M 2 F	7. Aga (In yrs. last birthda 57 Yrs.	y) If Under 1 Yaar Months Days	If Undar 24 Hrs. Houra Min.	8. Data of Birth (Month, Day	1943	9. Birthple	aca (State or Forei ry)
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urs after death of, or flering 234 Examiner must by Funeral	11. Marital Status  1 Navar Married 2 Xarried  1 Navar Married 2 Xarried  3 Widowed 4 Divorced  12. Was Dece	rcas? 2□ <b>X</b> No a	3. Was Dacedant of H If Yas, specify Cuba 1 Yas 2 X No	lispanic Origin? (Span, Maxican, Puarti Specify:	pecify Yaa or No- o Rican, atc.)		- Amarica k, Whita, e	
ed within 72 ho ygene. we then 'neturn it, the Medical is Completed	15. Decedant's Education (Specify only highast grade completed)	(Gir	cedant's Usual Occup ve kind of work done . DO NOT use retired	eation during most of world)	king	16b. Kind of Bu	sinass/Ind	ustry
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Wantal Hy riked other file event. To Be C	17. Fathar's Nama (First, Middle, Last)  John L. Jones Sr.				na (First, Middle, ie Tann		e)	
and 2 sho aith and h 27 is me r traume	19a. Informant'a Name/Relationship (Type, Print) Hattie Keys		illing Addrass (Street					
Pages 1 a next of Her ent if Hern any or othe	20a. Mathod of Disposition  1 XBurial 2 Cremation 3 Removal from 4 Donation 5 Othar (Specify)	cemetery, ca	position (Neme of rematory or other please on Bapt, (	CH Cem.		20c. Location - Seabo	ard	NC.
Departit Departit Imports any Inja	21. Signature of Funaral Sarvica Licensaa	1	22. Nama and Addra P.O. Box	ss of Facility 57 Sea	Faison aboard			me
certificate be executed and ding physicien and use as the burial-trensit and area as the burial-trensit and area are a few and	Immediata Causa (Final disaasa or condition resulting in daath)  Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Lest	Due to (or as a cons  Due to (or as a cons  Due to (or as a cons	Hestina equence of):	g car e ble	ecling	ma .		>   mon
atter for class	Part II. Other eignificant conditions contributing to de	ath but not rasulting in the	undarlying causa giv	van in Part I.	23b. Did t	obacco una cor	itribute to	the cause of de
that the de ed by the detached / Physic					1024	60 2□ No	3 Prob	ably 4 Unkr
ejclan: The lew requires that centricate has been signed director, page 2 should be del o Be Completed by P					24a. Waa perfo	an autopsy med?	ava con of c	ra autopsy finding illable prior to appletion of causa leath?
ysician: The list certificate he director, page	25. Was case rafarred to medical			26. Placa of Dee	eth (Check only o			
erthis leral of	27. Mennar of Death  Naturat 5 Panding (Mont	npatiant 2 ER/Outpat of Injury h, Dey Year) 28b. Time Injury	of 28c. Injur	4 LI Nursing H	loma 5 Rasid	ience 6 Oth		)
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completely filled in by the funera Medical Certification:	2 Could not be	of Injury - At homa, farm, ng, atc. (Specify)			28f. Location (S City or Tox	Street and Numb m, Stete)	er or Rura	Route Number,
To the Hospital or Attending within 24 hours after deeth.  To the Funeral Director: After completely filled in by the fur.  Medical Certification	29a. Cartifiar (Check only one)  1 Cartifying Physician: To the Description of the Description on the Description of the Descri	sis of axaminetion end/or	eth occurred et the til investigetion, in my o	me, dete end place ppinion, death occu	, and due to tha ourred at tha time,	causa(s) and ma deta and piece,	nnar es st	eted. tha causa(s)
To the To the comp	29b. Signature and titla of certifiar	5	29c. Licens			29d. Data signed		
	> Lithanha, m	1/	ATS	14389	46	Dec =	24,	2000
(2)	30 Nama and addrass of person who complated cause	of death (Itam 23a) (Typ	AT 2	hosp	ital,	Balti	mar	e,mp 21
State	31. Data filed (Month, Day, Year) DEC 2 7 2000	egistrar's Signatura	Sea v	,				



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State of Maryland / Department of Health and Mental Hygiene

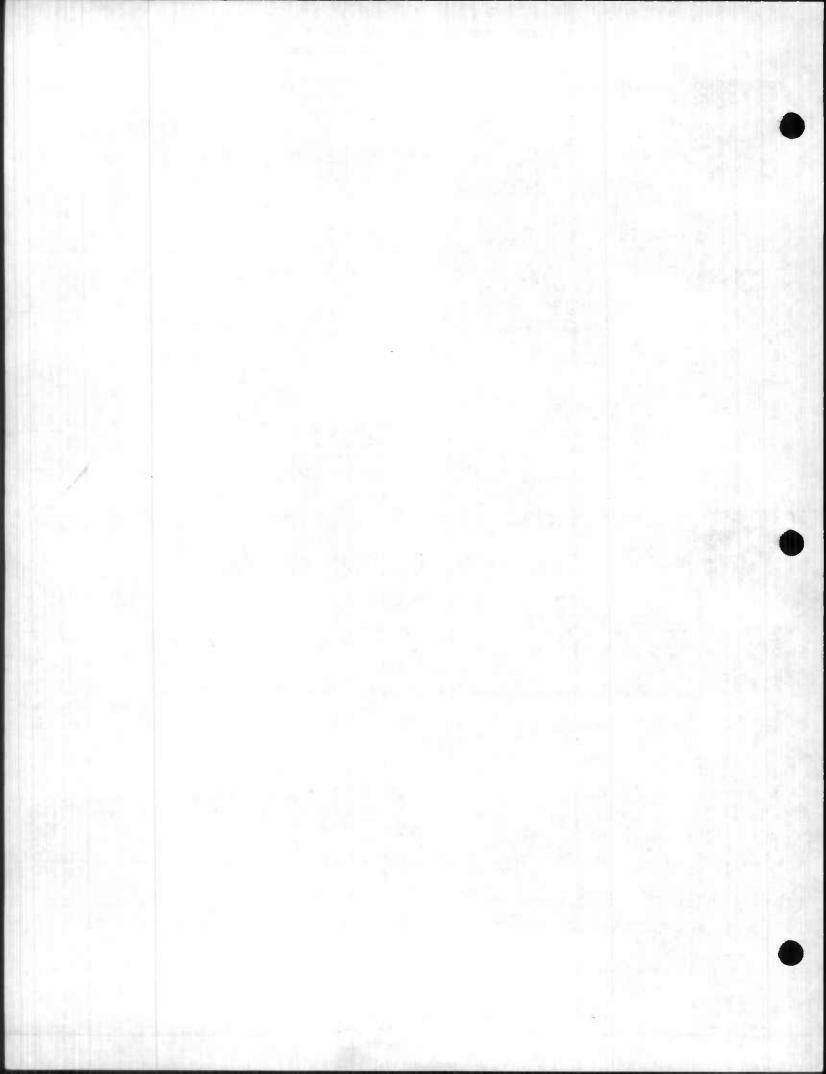
		Certificate of Death	Reg. No.
Physician	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 3. Time of Death
/Medical Examiner	Linwood Jones  4a Facility Name (If not institution, give street and number)  Doctors Hospital	4b. City, Town, o	12 25 2000 5:55 PI or Location of Death 4c. County of Death Prince George
Funeral Director	*	(In yrs. last birthday) If Under 1 Yeer If Under 24 H Months Days Hours M	Irs. 8. Date of Birth 9. Birthplace (State or For
	Usual Residence of Decedent	IOc. City, Town or Location	
and show iffled at ottor		Mitchellville	10d. Inside City Li 1 ☑ Yes 2 ☐
23e or 28e-1s ast be notified	10e. Street and Number 3602 Earlston Court	10f. Zip Code 20721	10g. Citizen of What Country? U.S.A.
af, or items 25 Examiner must by Funeral	11. Marital Status  1 Never Merried 2 Married  1 Never Merried 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ev Armed Forces?  1 Yes 2 No It Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)  14. Raca - American Indian, Black, White, etc.  Specify: Black
ypiene. Ner than "naturn It, the Medical. Completed	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12)  College (1-4or 5+) 5+		
	17. Fether's Name (First, Middle, Last)	Educator 18. Mother's N	Government  lame (First, Middle, Meiden Sumeme)
ed out	Wesley Jones		ttie Smith
d Mem	19e. Informant's Name/Relationship (Type, Print)		Rural Route Number, City or Town, State, Zip Code)
T is The	Evonne P. Jones/Wife		
Heal Dar 2	20a. Method of Disposition	20b. Place of Disposition (Name of	Mitchellville, Md. 20721  Date   20c. Location - City or Town, State
ment of ant: If the ury or o	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)	cametery, cremetory or other plece)	12/29/00 Landover, MD
Depart Import any in	21. Signature of Funeral Service Licensee		J.B. Jenkins Funeral Home Landover, MD 20785
ng physicien and es the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	ue to (or as a consequence of):  but substitute substitute substitute to (or es e consequence of):  ue to (or as a consequence of):	
been signed by the attendin should be detached for use leted by Physician/N	Part II. Other significant conditions contributing to death but	not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of de
oned by the set detached by Physical by Physical set of the set of	Hyperdension		1  Yes 2 No 3 Probably 4 Unit
certificate has been sign lirector, pege 2 should be o Be Completed by	Congestive heart	Jailine	24a. Was an autopsy performed?  24b. Were eutopsy tindia available prior to completion of caus of death?  1  Yes 2 No 1 Yes 2 No
ector, p	25. Was case referred to medical	26. Place of [	Death (Check only one)
	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	28b. Time of 28c. Injury at	g Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
as bler deeth.  al Diractor: After the in by the funera  Certification:	1 Matural 5 Pending (Month, Day's investigation 3 Suicide 4 Homicide (Month, Day's 28e. Placa of Injurbuilding, etc.)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29e. Certifier 1 ☑ Certifying Physician: To the best of	my knowledge, death occurred et the time, dete end ple xaminetion and/or investigation, in my opinion, death or d.	ece, and due to the cause(s) end menner es stated, courred at the time, date end placa, and due to the ceuse(s)
e Funeral bletely filled Adical C	(Check only one) 2 Medicat Examiner: On the basis of e and manner state		
within 24 hours To the Funeral I completely filled Medical Ce	(Check only 2 Medical Examiner: On the basis of e	29c. License number	29d. Date signed (Month, Dey, Year)
in 24 hourse he Funer pletely fill edical	(Check only one)  2 Medical Examiner: On the basis of e and manner state	29c. License number  D3 739 1	29d. Date signed (Month, Dey, Year)  12-28-00



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

					State	of Maryl		partment of ertificate of			Mental Hy	Reg. No.	42:	963
	Physicia	_	1. Decedent's Name								2. Date of De Month	eath Day	Year	3. Time of Death
	/Medica	_	Louise	Johnson	1								2000	11:00 PM
	Examine		te Facility Name (# 500 Jacq		ve street and nu	umber)			Bowi		Location of Deat	4c. County Prince		rge's
	Funeral Director		5. Social Security N 577–36–15		Sex 1 □ M 21∏ F	7. Age (In ) 91	rs. last birthda Yrs.	Months   Da		der 24 Hrs. S Min.	8. Date of Bir Month De DeCemb	er <sup>Yea</sup> 26,19	9. Birthp	laca (State or Foreign Louisiana
	2 .	-	Usual Residence of 10a. Stete	Decedent 10b. County		100	City, Town or	Location					-	0d. Inside City Limits
	n the Maryland or 28a4 show a notified at		MD	Prince	Coorgo		wie	Cocation						Y Yes 2 No
	25 Pa	Director	10e. Street and Nur		GEOIGE	3 100	WIC	10f. Zip Cod	la			10g. Citizen of V	What Cour	try?
The state of the s	23a or	in Die	500 Jacq					20721			Mark 1	U.S.A.		
980		by Fur	11. Marital Status 1 ☐ Never Marri 3 ☑ Widowed	ed 2 Married	12. Was Dec Armed F 1  Yes If Yes, G Year or D	orces? 25 No ive	n U,S. 1	3. Wes Decedent It Yes, specify C			pecify Yee or No o Rican, etc.)	Specify	a - Americ ck, White,	
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2121	their their the Me	Completed	Elamantary/Seco			(1-4or 5+)		es Repre				Privat	e	
Maryland 21215-0036	2 T 10 5	o Be C	17. Falher's Name ( Charlie		")					other's Nar ry Ma		, Maidan Suman	ne)	
POMAN.	nd 2 show alth and N 27 is mer r traumat		19a. Informent's Na Charles	me/Reletionship (M. John	(Type, Print) SON			Jacque					State, Zip	Coda)
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Balt	Departi Departi Importa any Inji		21. Signiflure of Fu	Viral Service Lips	nsee			22. Name and Ad 7474 Lan						Home
			23a. Part1. Enter the shock, or hea	n disease, or con	plications that	caused the d	leeth. Do not	enter the mode of	dying, such	as cardia	or respiratory a	ırrest,	1	Approximata Interval Batween
	Physician /Medical Examiner		Immediate Cause (	Final				monary sequence of).						hours
E.			rasulting in deeth)								1			
	per is	u u			b.   Da	up V	mous	Throw	. 605	1			i	monTas
	and nand	Examine	Sequantially list coil eny, leading to in cause. Enter Unde Cause (Disease or	nditions, mediate		" Due t	o (or as a cons	sequance of):						
(68760,	hysicia	dica	Cause (Disease or that initiated events resulting in deeth) I		c	Due to	o (or es e cons	sequence of):		17.				
Box	death certif s attending d for use a	cian	Part II. Other signif	cant conditions	contributing to a	leath but nat	resulting in the	a underlying cause	given in P	ert I	23b. Did	tobacco uea co	ntribute t	the cause of death?
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ords	e law requires that the death hes been signed by the atte ge 2 should be deteched for	Completed by Physician/Me										s an autopsy omed?	av	ara autopsy findings ailable prior to impletion of cause death?
E.	The late he page	E									10	Yas 2 No	1 (	Yes 22 No
ita	ician: The certificate rector, pag		25. Was case rafer	red to medical					26. P	laca of De	ath (Check only	ona)		
of <	Physician: this certific ral director,	0	axaminer?	No			2 ER/Outpal	tient 3 DOA	Other: 4	Nursing H	iome 5 Res	idance 6 □Oth	ner (Specia	(y)
	Attanding Pi		27. Manner of Deatl  1 □ Naturel  2 □ Accident	5 Pending investigation	n	of Injury oth, Day Yea	28b. Time Injur		njury at Work? 1 ☐ Yes 2	! □ No	28d. Describe	how injury occur	rred	
	s after de	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not to	28e. Plac build	e of Injury - A	At home, farm, ecify)	street, factory, off	ice		28f. Location City or To	(Street and Numi own, State)	ber or Run	al Route Number,
	Hospi 24 hou Funer stely fill	edicai	29a. Certifier (Check only one)		miner: On the b			ath occurred at the investigation, in n						
	To the To the comple	-	29b. Signature and					-	ense numb			29d. Date signe		
		1	Roin	tan tara	di fan !	7.0.			1434			Decembe		
	(3)		30. Neme end addr	ess of person who				De, Print) DI George	sia A	ve s	uit 3-	35 SILV	ER S	MP 20907 PRING
	Stat		31. Date filed (Mon	th, Day, Year)	32.1	Registrar's Si	ignature	> 4 4 4	0					
	Registra	r	DEC	2 8 2000	per	wa	Ø.	South	1					

Registrar DHMH 16 Rev 6/95



Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefie Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Month Edward December 25, 2000 8:20 PM Lee Jones 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Sacurity Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Months 225-46-2295 10XM 20 F 58 Deys Hours Yrs. January 7, 1942 Danville, VA Usual Rasidence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yas 2□No Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4110 Silver Park Terrace 20746 United States 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Reca - Amarican Indian, Black, Whita, atc. 11 Maritel Stetus 1 ☐ Nevar Merried 2 ☐ Married 1 Yes 2 XNo Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 7 years CEO of L&J Trash Company Self Employed 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Charlie Jones Gladys Jones 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Lillie Wood - Wife 4110 Silver Park Terrace Suitland, MD 20746 20e. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata ☑ Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata Washington National Cemetery Donation 5 Other (Specify) 12/30/2000 Suitland 21. Signature of Funaral Sarvine La 22. Nama and Addrass of Facility Stewart Funeral Home, Inc. 4001 Benning Road, N.E. Washington D.C. 20019 23a. Perf 1. Exter the disease, or complications that cause shock, or leart failure. List only one cause on each line not antar tha moda of dylng, such es cardiec or respiretory arrast, Approximeta Intarval Batwe Onsat and Death tmmediata Causa (Final disaasa or condition rasulting in death) ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): CORONARY ARTERY PISEMSE Dua to (or as a consequence of) HYTERTEMSIVE CARPIOVASCULAR DISEASE Dua to (or as a consequence of) CONGESTIVE HEART FAILURE Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Wara autopsy findings availeble prior to complation of cause of death? 24a. Was en autopsy performad? 1 Yas 2 No

**Physician** /Medical Examiner

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ed by the detached

page 2 s is certificata l director, pag

After this

Director:

by

Completed

Be

To

Certification:

edicai

3 ☐ Suicide

4 Homicida

29b. Signatura end titla of bertifian

that the death certificate be executed

Physician:

or Attending

death.

after

24 hours

To the To the To the F

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy
Important: If them 27 is merked other any Injury or other traumatic.

**Physician** 

/Medical

Examiner

Directo

Funer

þ

Completed

**Funeral** 

Directo:

event, the Medical Examiner must be notified at

Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disaase or Injury that Initiated events rasulting in death) Last

1 Yas 2 No

25. Wes casa rafarred to medical 26. Plece of Death (Check only ona) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No

27. Mennar of Death 28b. Tima of tx Natural 5 Panding invastigation 2 Accident

28c. Injury et Work? 1 Yas 2 No 28a. Placa of Injury - Al homa, farm, straat, factory, office building, etc. (Specify)

28d. Dascribe how injury occurred 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29e. Certifian (Check only one)

Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the causa(s) and mannar as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29d. Date signed (Month, Day, Year)

6 Could not be determined

29c. License number

2000

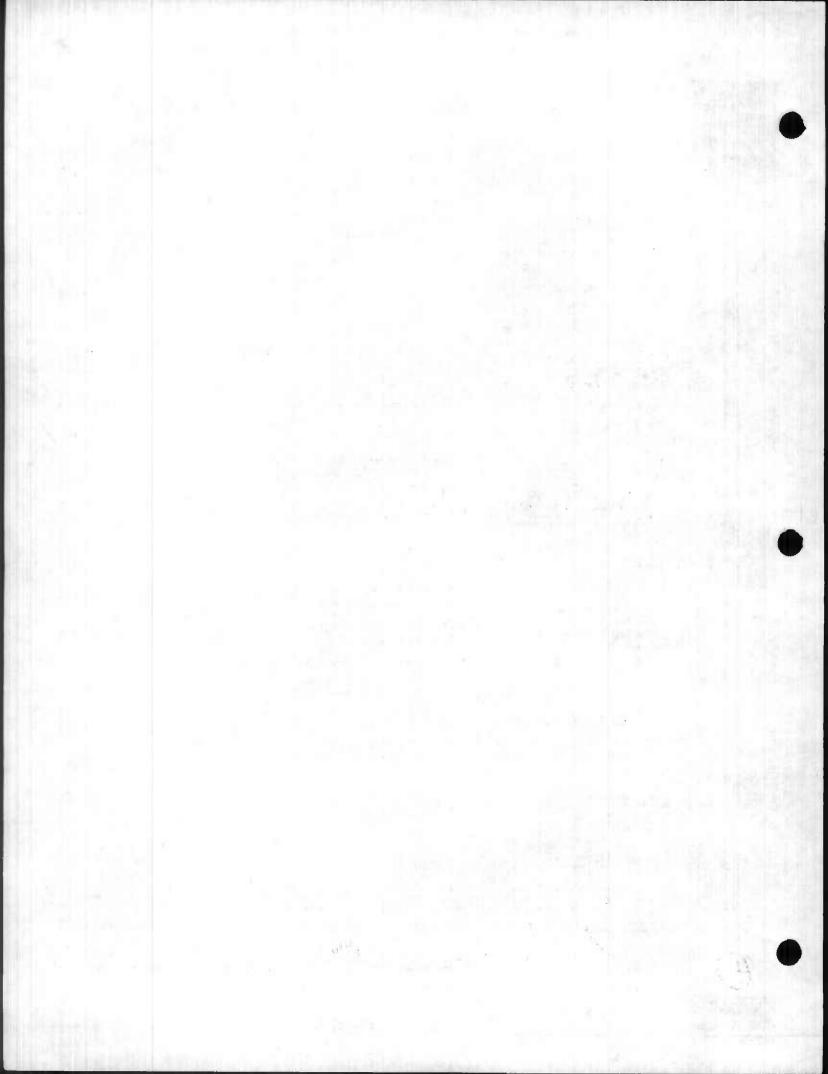
30. Name and addrass of person who complated causa of daath (Ilem 23a) (Type, Print)

SELWYN

State Registrar

Southern MARYLAND HOSPITAL GENTER CLINTON MP, 20735 31. Dete filed (Month, Day, Year) DEC 2 8 2000 Registrar's Signature

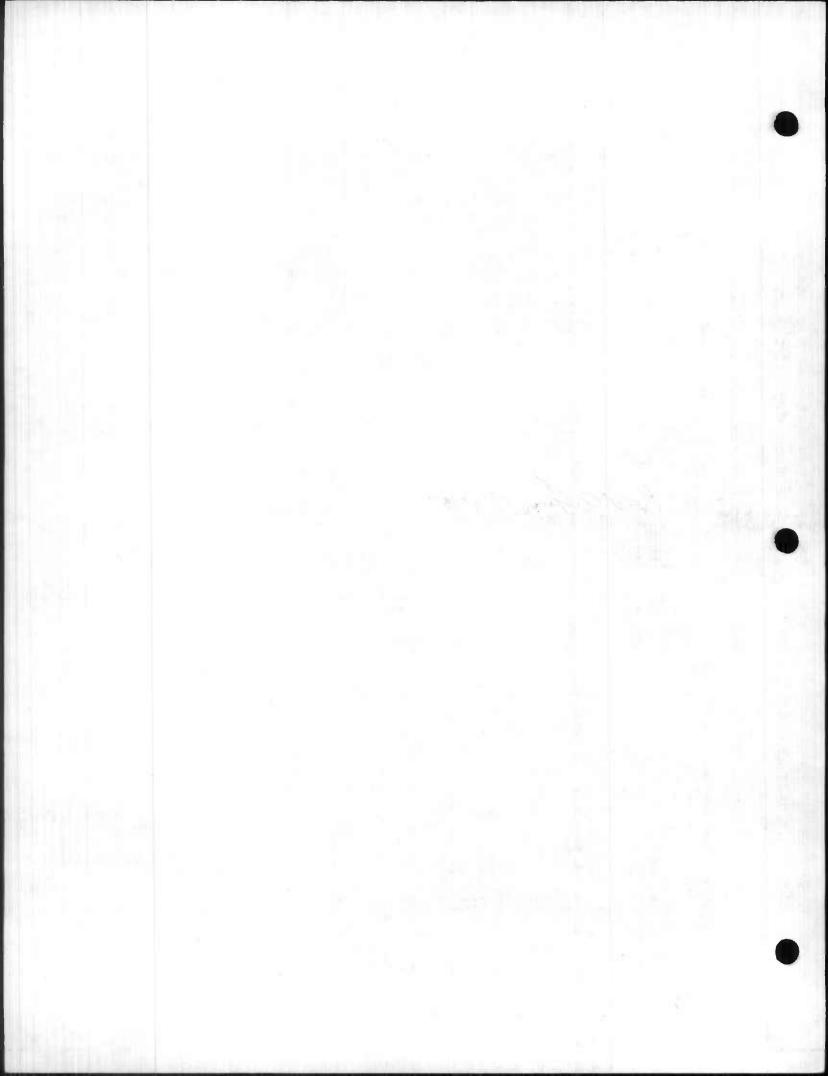
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State of Maryland / Department of Health and Mental Hygiene 0 42967

						(	Certifica	ate of	Death		Reg. No.	4	1067
	Di vivi	_	1. Decedent's Name (First, Middle, La	est)				-		2. Date of Dea Month	ith	Year	3. Time of Death
	Physiciar /Medica	_	Jung Ja Kim								ev 26, 2		1515
3	Examine		la Facility Name (If not Institution, gir		,		# _		4b. City, Town, or I				
			6/26 Surrey	Square	Le	re	#201		For est 1	* *		2 6	earge's
	Funeral Director			Sex		last birth	Month	ler 1 Year s Deys		8. Date of Birth Month, Day July 19	, Year)	Counti	aca (State or Foreign ry) L
	pue *	-	Oa. State 10b. County		10c. Ci	y, Town	or Location					10	d. Inside City Limits
	Mery	E N	Maryland Prince G	enrae's	F	oraci	tville						1⊡Yes 2□No
	28e	9	Oe. Streel and Number	0180 0		OLCB		ip Code			10g. Citizen of W	hat Counti	ry?
	iter death with the Me r Heme 23e or 28e-fe iner must be notified	2	6126 Surrey Squa	re Ln. #20	1			207	47		Korea		
	dead dead	100	1. Marital Status	12. Was Decedent Armed Forces?	Ever in U	,S.	13. Was Dec	edent of	Hispenic Origin? (S pan, Mexican, Puert	pecify Yes or No-	14. Race	- America	
5-0020	or Paris	2	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 N If Yes, Give Year or Dates:					Specify:	o rican, etc.)		Kore	
	"natural",	25	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. D	ecedent's Us Give kind of a	uel Occu	petion during most of wor	kina	16b. Kind of Bus	siness/Indu	ustry
121			Elementery/Secondary (0-12)	College (1-4or !	5+)			use retire	during most of wor ed)				
CA	Hygie Hygie		7. Father's Name (First, Middle, Last	1	-		Nurse		19 Mothar's Nam	ne (First, Middle,	Medica		
	2 should be filed within and Mental Hygiene. Ie marked other than aumatic event, the March To Re Comp.	ŏ	Unk							ul Bang	walden Sumeme	,,	
7	and Meni		19e. Informant's Name/Relationship	Type Printl		19b A	Anilina Addre	es (Stree	t and Number or Ru		r City or Town	State Zin (	Codel
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re,	E SE SE	1	InSang Jung / Section InSang Jung / Section	311	20b. I	tace of D	isposition (A	ame of		Date	20c. Location - (		
Baitimore	00		1 ☐ Burial 2 【3 Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci				crematory of			12/28/00	Beltsvil	lle,	Md.
Ħ	permit. Page Department of Important: If any injury or once.	-	21. Signature of Funeral Service Lice		Che	sapea	ake Cr 22. Name		ess of Facility				
Ä	Departr Departr Imports any inj		14101	MO	colo				er S. Pop				
-		+	23a. Part1 Enter the disease, or born shock, or heart feil for List only	plighton that caused	the deal	h. Do no	553 t enter the m	8 Mar	rlhoro Pi	ke/Fores	tville,		20747 Approximate
	Physician		shock, or heart felling. List only	one cause on each li	10.								Interval Between Onset and Death
	/Medical		Immediate Ceuse (Final disease or condition	Ath	205	of no	Ti:	C	9 rdio UM	x el la	Direa		
	Examiner	1	resulting in death)	a			nsequenca o		,, , , , , , , , , , , , , , , , , , , ,	300,00	-13 44		
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90,	icate be execu physician and s the burial-tra		any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events										
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	ires that the deeth certification is gined by the attending does detached for use a by Physician/A	F	Part II. Other significant conditions of	contributing to death b	ut not res	ulting In I	ne underlying	cause g	iven in Pert I.	23b. Dld t	obacco use con	tribute to	the cause of death?
0.	that the the detail details									101	/es 2□ No	3 Prob	ably 4 Unknown
ഗ	signe d be d						31.77			24a. Was a	an autoney	24h Wei	re autopsy findings
Ö	law requires les been sign 2 should be										med?	avai	ilable prior to
Record	e - A -	1											eath?
= 1	certificate he rector, page		SF 184							1 U Y		1 🗆	Yes 2□ No
Vital	Physician: this certific ral director,		25. Was case referred to medical examinar?  1 ✓ Yes 2 ☐ No	Hospital:		5010		0	hor	th (Check only o		(D = 1)	
	Physic rthis c arai dire		7. Manner of Death	1 ☐ Inpatie	гу	28b. Tin	atient 3 1	28c. Inju	4 Li Nursing n	ome 5 Hesid	ow injury occurre		,
0	th. After funer		Netural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	Year)	Inju	Iry M		ork? ]Yes 2∐No				
Division	or Attending after deeth. Director: After I in by the fune		3 Suicide 6 Could not b	e 28e. Pleca of Ini	ury - At h	ome, fam	, street, facto	ory, office		28f. Location (S	treet and Numbe	er or Rurel	Route Number,
Ď.	tal or Attending P is after deeth.  al Director: After t ed in by the funer Certification:		4 Homicide	building, ef	: (Specil	y)				City or Tow	n, State)		
	To the Heaptial or Attending Physician 24 hours after death completely filled in by the funeral Medical Certification: "Medical Certification:"		29a. Certifier (Check only one)  1 Certifying Ph	ysician: To the best on the basis of and manner sta	examine	wledge, d	eath occurre	d at the t	ime, date and place opinion, deeth occu	, and due to the c rred at the time, c	ause(s) and mar date end plece, a	nner as sta nd due to	ited. the cause(s)
	Vithin To the		9b. Signature and title of certifier				2	9c. Licen	se number	1	29d. Date signed	(Month, D	lay, Year)
	7120		1 do londo	lete	20			Hon	55-925	7	Dece 10	2,1	7 2000
	(2)	3	0. Name and address of person who	completed cause of d	eath (Iten	23a) (Tv	rpe, Print)		0 / / /	-		0	4 - 200
	(5)	2	Alvadon S/VS  11. Date filed (Month, Day, Year)	Ter, 300/	Ho	3917	tal I	riv	e Cher	el 19	ary lan	d	20785
	State Registrar		DEC 2 9 2000	Senter	/	4.	Span	6					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEM: 23 PART I, PER PHY G791 State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** 2000 · 1:15 AM Charlotte Evelyn Kirwan 16 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Cambridge
If Undar 24 Hrs. 8. Data of Birth
(Month, Day, Year) Chesapeake Woods Center Dorchester If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months Days 1□ M 2□F Yrs. 215-16-8747 95 Sept 27, 1905 Director Maryland Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Xxas 2 □ No Dorchester Maryland Cambridge Directo than "natural", or hems 23s or 28s-the Medical Examiner must be notifi 10f. Zip Coda 10e. Street and Number 10g. Citizan of What Country? 525 Glenburn Avenue Funeral 21613 US Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? 11. Marital Status 1 Yas 20 No If Yas, Give Yaar or Dates: Maryland 21215-0020 1 Navar Marriad 2 Married 1□ Yas 2√No Spacify: Specify: à Widowed 4 □ Divorced White Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Surnama) 88 is marked John Wesley Hurst Katherine Beckwith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) partment of Health a ortant: If hem 27 is 107 Linthicum Drive Cambridge, Maryland 21613 ce of Disposition (Nama of Data 20c. Location - City or Town, Stata Joyce K. Turner Daughter Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Pages nent of h MX Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Constion 5 □ Other (Specify) East New Market Cemetery 11/18/00 East New Market, MD 21 Signature of Funeral Sarvice Licensea 22. Nama and Addrass of Facility Thomas Funeral Home, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Daath **Physician** /Medical Immediata Causa (Final · Chronic Brain Syndreme O years disaasa or condition resulting in death) Examiner Due to (or as a consequence of)
ALZHEIMER'S DISEASE 20 YEARS Physician/Medical Examin Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disease or injury that initiated evants rasulting in death) Last use as the bunal-tran Due to (or as a consequence of) certificate be axecu ed by the attending physician detached for use as the bure Box 68760 Dua to (or as a consequence of): The law requires that the death Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Status post Craniotomy by Division of Vital Records. 24b. Wara autopsy findings availabla prior to completion of causa of death? page 2 should 24a. Was an autopsy Completed performed? this certificate has 1 ☐ Yas 2 ☐ No 1 Yas Physician: after death.

Director: After this certification of the funeral director, 25. Was case ratarred to medical Be 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Jursing Home 5 Rasidance 6 Othar (Specify) 1 Yas 2 To 27. Manner of Death edical Certification: 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Watural 5 Pending invastigation 1 Yas 2 No 2 ☐ Accident 6 Could not be datamined Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify) illed in by or A after 4 T Homicide To the Hospital within 24 hours a To the Funeral Completaly filled 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian (Check only one) 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and titla of certifian

State Registrar

31. Data filed (Month, Day, Year) 32. Regis

Kobrusor

NOV 1 7 2000

30 Name and address of person who complated causa of death (Itam 23a) (Type, Print)

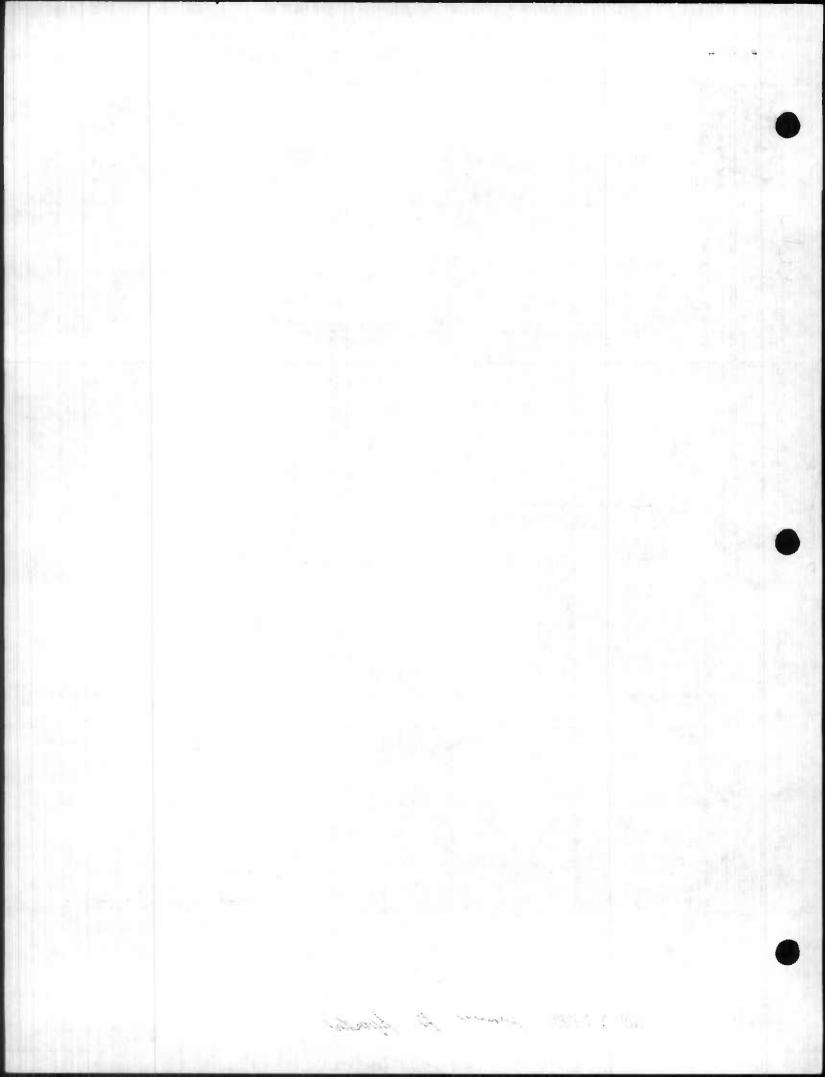
32. Registrar's Signatura

Sparks

211284

11.16.00.

Cambridge MD 21613



FRANCES KINGSTON

### Please Type or Print in Biack Indelible Ink. Assure Ali Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

Silver Spring

10f. Zip Code

State of	Maryland /	Department of Health and
		Certificate of Death

**Physician** /Medical Examiner

LUCIA KINGSTON FRANCES 4a Facility Neme (If not institution, give street end number)

2. Dete of Deeth DECEMBER 20, 2000

8. Date of Birth (Month, Dev. Year)

May 30, 1939

3. Time of Death 4:16P.M.

Birthplece (State or Foreign Country)

10d, Inside City Limits 1 Yes 2 No

Liberia

UNIVERSITY HOSPITAL 5 Social Security Number

10b. County

1. Decedent's Name (First, Middle, Last)

7. Age (In yrs. last birthdey) 1 M 2 X F

Yrs.

10c. City, Town or Location

BALTIMORE If Under 24 Hrs. Months Deys Hours

4c. County of Death

**Funeral** Director

Director Funeral by

10s State 11. Meritel Stetus 1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

Md.

the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 2 page, injury or other traumatic avent, its Middle Institute manages.

Physician

/Medical

Examiner

attending physician and for use as the burial-tran

After this certificate has funeral director, page 2:

Director: /

Hospital or Attending I 24 hours after death.

To the Hospital or Atterview within 24 hours after der To the Funeral Directo completely filled in by the

the death certificate be executed

Division of Vitai Records, P.O. Box 68760,

Examiner

Physician/Medical

þ

Completed

Certification:

edicai

Baltimore, Maryland 21215-0036

220-43-6314 Usuel Residence of Decedent

Completed 86

10e. Street and Number 525 Thayer Avenue

Montgomery

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Detes:

20910 Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian, Bleck, White, etc. Black

10g. Citizen of What Country?

Liberia

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th

College (1-4or 5+)

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper

1 Yes 2 No Specify:

Domestic

16b. Kind of Business/Industry

17. Fether's Neme (First, Middle, Last)

Johnny Greene

Maltilda Greene 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

18. Mother's Neme (First, Middle, Meiden Sumame)

4b. City, Town, or Location of Death

19e. Informent's Neme/Reletionship (Type, Print) Ruth K. Singleton/Daughter

5320 Wiley St. 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) Riverdale, Md. 20737 20c. Location - City or Town, Stete

20e. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete

Gate of Heaven Cemetery 1-06-01

Silver Spring, Md.

4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses

a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one ceuse on each line.

22. Name end Address of Fecility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC Approximate Intervel Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in deeth)

Arteriosclerotic Cardiovascular Disease Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest

Due to (or es e consequence ot):

Due to (or as e consequence of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Diabetes Mellitus

24e. Wes en eutopsy performed? INSPECTION 24b. Were eutopsy findings evaileble prior to completion of cause of deeth?

1 ☐ Yes 2 No

26. Plece of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

Be 25. Wes case reterred to medical 2 1 Yes 2 No

27. Menner of Death 1 Natural 2 ☐ Accident 5 Pending investigation

6 Could not be determined

28e. Pleca of Injury - At home, term, street, tactory, offica building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA Injury

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 281. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end menner stated.

29b. Signeture and title of certifie

29c. License number O.C.M.E.

29d. Date signed (Month, Dey, Year) DECEMBER 21,2000

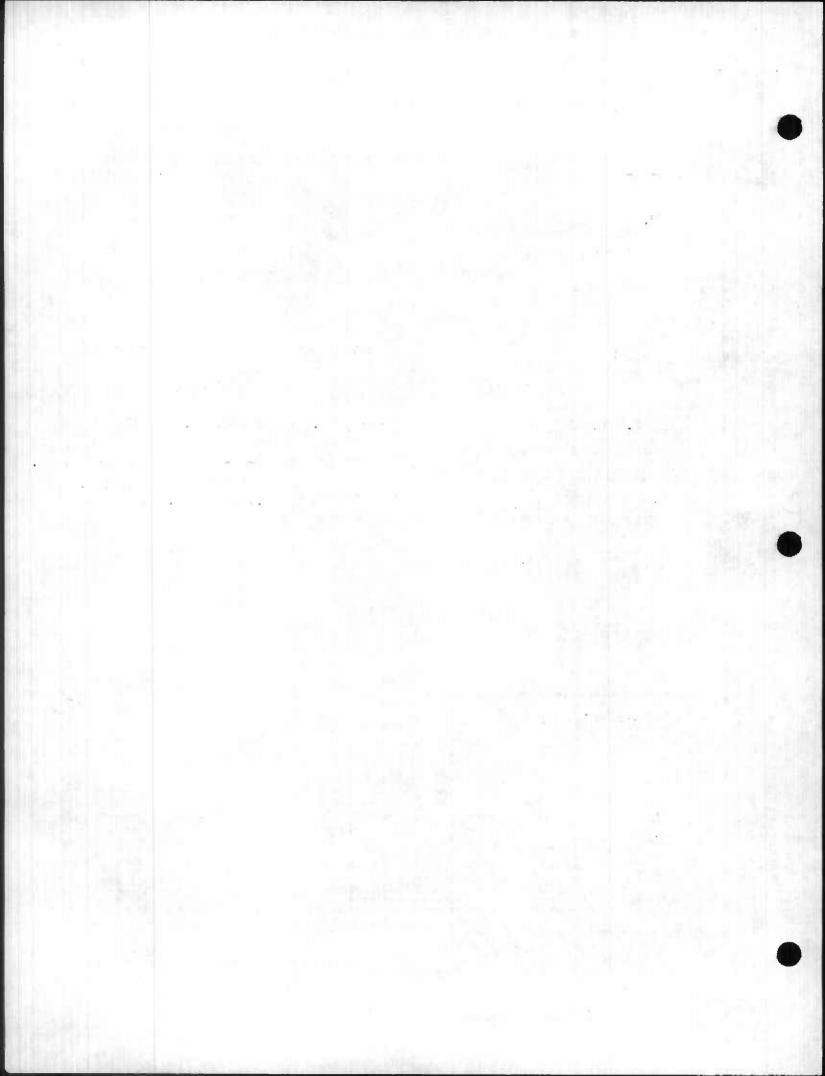
30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

MARY G.RIPPLE M.D.

111 Penn Street, Baltimore, Maryland 21201

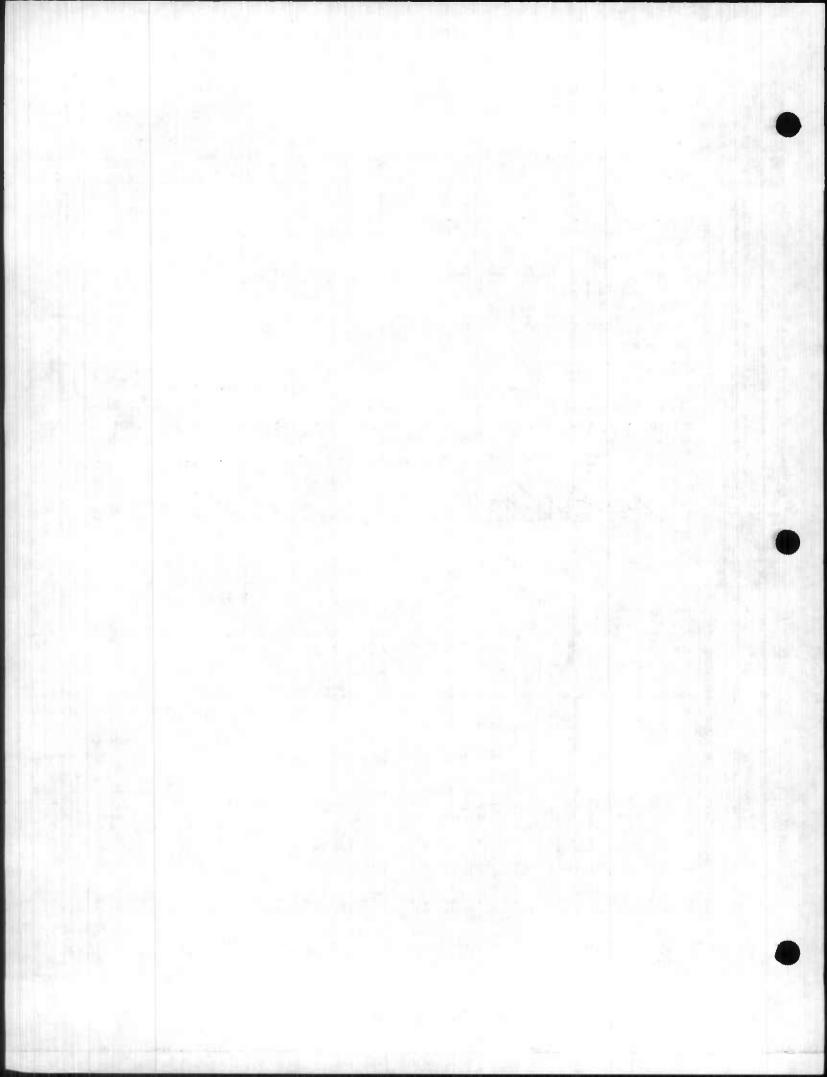
Registrar

31. Date filed (Month, Day, Year) DEC 2 6 2000 3. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

	COLUMN STREET				0.0.0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	i y iai io	Ce	rtificat	e of	Death		Reg. No.	) 1	+2970
п	Dhusiaia	-	1. Decedent's Name	(First, Middle, La	st)				1985			2. Date of De Month	Dey	Yeer	3. Time of Death
ą,	Physiciar /Medica		Annie Ma	e Lesiuk								DECEMB		an	
1	Examine	r	4a Facility Name (If	not Institution, giv	e street and nu	mber)				4b. City, Town, or L	ocation of Deet	h 4c. Cour	nty of De	alh	
		4	Union Ho				4		If Under	1 Voor	Elkton If Under 24 Hrs.	Ta 5 (D)	Cec		
	Funeral Director		5. Social Security Nu 248-20-6] Usual Residence of	.37	ex I□M 2∏ F	7. Age 75	(In yrs. la	rst birthday, Yrs.	Months		Hours Min.	8. Dete of Bir (Month, De APR 16			inthplace (State or Foreign Country) uth Carolina
	th with the Maryland 23a or 28a-f ahow		10a. State	10b. County				Town or L	ocation		150.0			78	10d. fnside City Limits 12 Yes 2 □ No
	No M	2 -	Maryland	Cecil			Elk	ton	1						
	with the		10e. Street and Num						10f. Zip				10g. Citizen a		
	a 23	6	1 Price	Drive	12. Was Dec	adant Ex	er in II S	12		921	dispanie Origin? (Sr	poity Ves or No	Unite		ates nerican Indian,
21215-0020		by runeral	1 Never Marrie		Armed For 1 Yes If Yes, Gi Year or D	orces? 2 <b>T</b> No		. 10.	ff Yes, spe		dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Spec	lack, Wh	
2-0	72 ho	Completed	/Sneci	15. Decedent's Ed fy only highest gra	ducation			16a. Dece	dent's Usua	al Occup	pation	kina	16b. Kind of	Busines	s/Industry
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	filed withi Hygiene. ther than	3	10					Home	maker						n Home
pug	\$ E D A	ň	17. Father's Name (I	First, Middle, Last,							18. Mother's Nam			eme)	
Maryland	should the marked umatic	0			Woote	en						Irene !		0	7. 0 ()
Ma	d 2 sh h and r is m traum		19a. informant's Na							- 117	end Number or Ru				
a î	Healt Healt Her ther		Michael. 20a. Method of Disp	E. Lesi	ik/Son	- 9	20b. Pla	ace of Disp	sition /Ner	ne of	cle, Elk	Date	_		or Town, State
mor	P P P P P P P P P P P P P P P P P P P		1 Durial 2	Cremation 3		State	Cet	metery, cre pin M	metory or o	ther ple	min'i				
量	The Party of the P	-	21. Signature of Fug	5 Other (Specif			Par	k			ess of Facility	1/2/01	Elkton	1, Ma	aryland
Ba	Page and Company		bolo	11 0.	1/	. /	1	Н	icks	Iome	for Funer				
-		+	2 San Page Figher to	e diseaseds com	Hallow's that	caused ti	he death				ckton Stre			ryla	nd 21921 Approximete
	Physician /Medical		shock, or hear	tailure. List only	one cause on	sach line	0	9+	Coc	o h	~ 18	nter	cton		Intarval Between Onset and Death
	Examiner		resulting in death)	To 13	a. Hou	1	ue to (or	as a conse	quence of):		140	0	~		1
	P # 5				. 16	ce	mi	Suf	ر در	7	Lanly	0_	2 to	a	1 days.
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68760	physicien the burie	0	that initiated events resulting in death) L			Di	ue to (or a	as a conse	quence of):	/					approx
					d										
Вох	iras thet the death cert signed by the attending d be detached for use	ומו													
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Vital Records,	v requires thet the death cert been signed by the attending should be detached for use		the	no. to	1.00		6	. 1	61		1. Du	24a. Was	s an autopsy ormed?	241	. Wera autopsy findings available prior to
000	_ 00	Die.	11/1	11-4E	NO 81V		Ca	rai	OVE	U)C	Wis	ease "			completion of cause of death?
m.	The law ate has page 2		0.									10	Yes 20 No		1 ☐ Yes 2 ☐ No
ital	certificate		25. Was case raferro	ed to medical		/					26. Placa of Dea	th (Check only	one)		
of V	5 00		examiner?	60	Hospital:	Inpatient	1 2 DE	R/Outpatie	nt 3 D	DA ON	her: 4 Nursing H	ome 5 Res	idence 6 🗆 (	Other (S)	pecify)
	ding Ph h. After th funeral		27. Mannar of Death 1 ☑Natural	5 Pending	28a. Date (Mon	of Injury	Year)	28b. Time of finjury	of	28c. Inju Wo	ry at rk?	28d. Dascribe	how injury occ	curred	
Sio	Attending or deeth.  octor: After by the fune	IRS	2 Accident	investigation					М	1 🗆	Yes 2□No				
Division	is after deeth.  al Director: After ted in by the funer.		3 ☐ Suicide 4 ☐ Homicide	determined	288. Place	e of Injur ing, etc.	y - At hon (Specify)	ne, farm, si	reet, factor	y, office		28f. Location City or To	(Street end Nu own, Stete)	m <i>ber or</i>	Rural Route Number,
	urs as united in the second		00-0-17-1												
	To the Hospital within 24 hours a within 24 hours a Completely filled	200			nfner: On tha b		xaminatio				me, data and place opinion, death occu				
	within 7 to the comple		29b. Signature and t	itle of certifier	0 0 1	1			29	c. Licens	se number		29d. Date sig	ned (Mo	nth, Dey, Year)
	PSFO		Ka	pertil	lel-10	160	7-1	mi	)	2	7223	107	121	12	8/00
	2		30. Name and addra	ss of person who	complated caus	se of das	ath (Itam :	23a) (Type	. Print)			1	_ /		/
			JAYAI	YTILA	LKT	97	EL	MD	1235	The	erly	the,	ELKT	1074	(M)21921
	State	:	31. Date filed (Mont)		Se 32. F	Registrar	's Signatu	ore do	10	0	1				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month December 28, 2000 Anne Gibson Lanpher 9:28 P.M. 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Collington Episcopal Life Care Mitchellville Prince Georges If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sax 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months Hours 1 M 2 F 90 552-12-6886 February 1, 1910 Scotland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Georges Mitchellvile 1 □XYes 2 □ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 10450 Lottsford Road 20721-2124 United States 14. Race - Amarican Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 12 4 17 Fathar's Name /First Middle ( ast) 18. Mother's Nama (First, Middle, Maiden Sumame) Edward Gibson Magdalene Sutherland Logie 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Coe Langher/Son 11 Graton Street, Chevy Chase, MD 20815 December 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Steta Wash. University 4 Donation 5 ☐ Other (Specify) Washington, D.C. 2000 Signature of Funeral Service License 22. Nama and Addrass of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition rasulting in death) PN FUMON, A 2 WEEKS Due to (or as a consequence of): CHOWNIC OBSTRUCTUS PULMONARY DISPASE 20 YFARS Due to (or as a consequence of): LARYNUFAL CARCINOMA 40 YFARS Due to (or as a consequence of):

**Physician** /Medical Examiner

physician and the burial-transit

use.

page 2 s

this

After

To the Mospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the lun.

Box 68760.

P.O.

Records.

of Vital

Division Attending

The law requires

permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Medonce.

**Physician** 

/Medical

**Funeral** 

Director

than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

P

Completed

the Marylend

death

72 hours after

Baltlmore, Maryland 21215-0020

Examiner Physician/Medical by Completed Be Certification: To

29b. Signeture and title of certifier

31. Dete filed (Month, Day, Year)
DEC 2 9 2000

loper

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events rasulting In death) Last 40 YFARS AKTERIUSCLEROSIS Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown HYPERTONSION 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? CHRONIC LYMPHOCYTIC LEUKEMIA 1 Yas 20 No 1 ☐ Yas 2 No 25. Was casa referred to medicel examiner? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 | Yes 2 | No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar GREENWAM GENTER DRIVE 22. Registrar's Signatura

30. Name and address of person who completed causa of death (Item 23a) (Type, Print) RUTH LOPEZ, MO

GREENBELT, MO

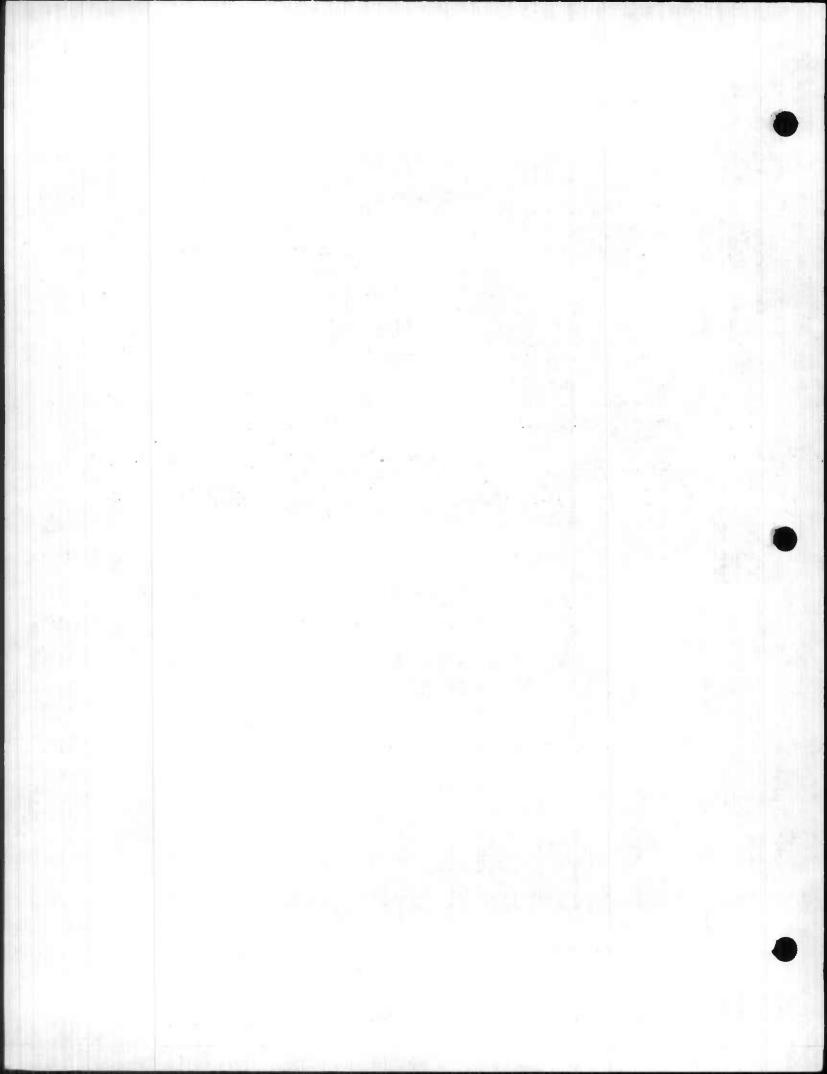
29c. License number

D46834

29d. Date signed (Month, Day, Year)

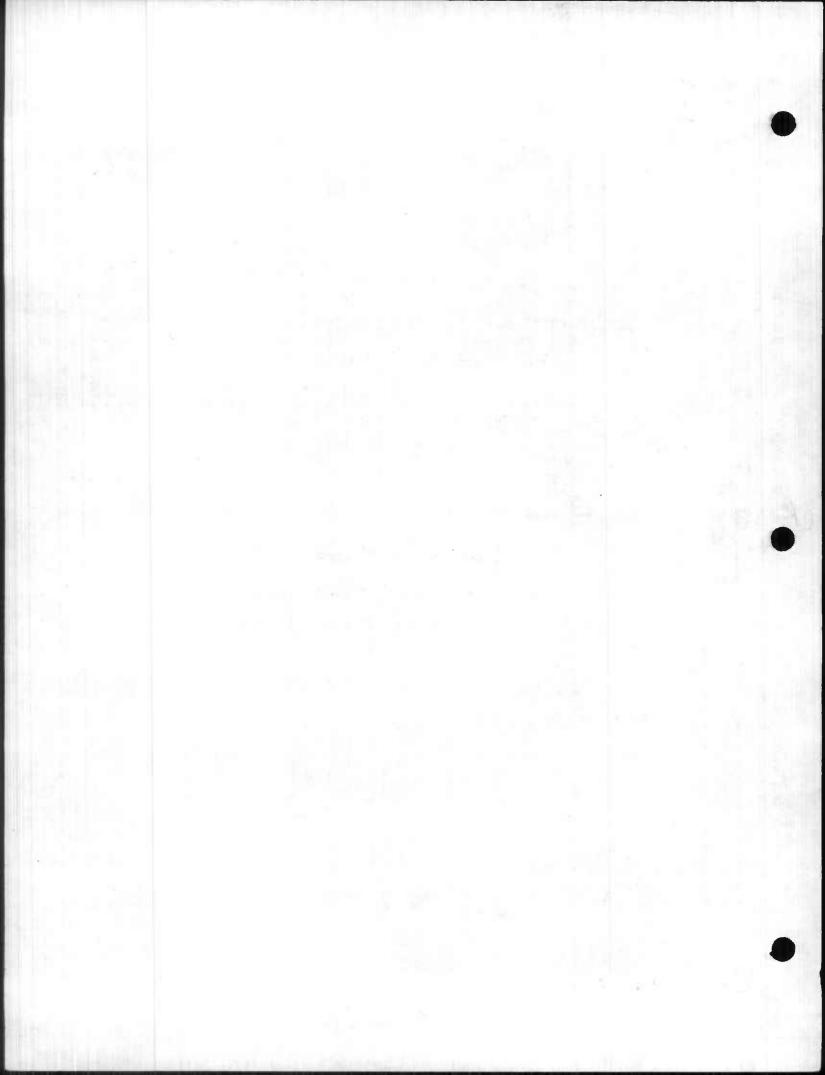
12-29-00

20770



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** 35 pm S, -ANIXI 5-2000 /Medical 4b. City, Town, or Location of Deeth Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner ANS. NSQ STUD. Laurel, MD Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Months 10 M 20 F 217-32-2426 Director 2-21-1937 Maryland Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show THE 23s or 28s-f show Prince George's Suitland 1 Ves 2 □ No Funeral Director 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 3827 Swann Road 20746 U.S.A. , or items 14. Race - American Indien, Black, White, atc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) than "natural", or item the Medical Examiner filed within 72 hours after 1 Never Married 2 Merried 1 Yes 2 No
If Yes, Give
Yeer or Detes: 21215-0020 1 Yes 2 No Specify: Specify: Black. þ 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Businass/Industry ith end Mental Hygiena. 27 is marked other than "r r traumatic event, me Med Government Elemantary/Secondery (0-12) 12th Collega (1-4or 5+) Printer Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumama) . Pages 1 end 2 should be fill ment of Heelth end Mental Hant: If item 27 is marked oth lury or other traumatic even Rufus Landis Ethel Patterson 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robyn Landis Jackson/Daughter 7000 Muir Dr Fort Washington, MD 20744 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete permit. Page Department of Important: If eny Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Harmony Cemetery 12-28-00 Landover, MD 21. Signature of Funaral Service Licerus 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785 23a. Pert1. Enter the disease, excomplications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** /Medical Immediate Ceuse (Final alure to thrive 6 months disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner no trinjand ician end burial-transit The law requires that the death certificate be assecuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or es a consequence of) Aretery Box 68760. Coronaky Physician/Medical physi the b Due to (or es e consequence of) detached for use Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 € Unknown Yakken sonis m Division of Vital Records. þ be 24b. Wera autopsy lindings available prior to completion of cause of deeth? Completed 24e. Wes an eutopsy performed? 1 Yes 2 XNo 1 ☐ Yes 2 No or Attending Physician: Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatiant 2 ER/Outpetienl 3 DOA 28a. Date of Injury (Month, Dey Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending invastigation 1 Netural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner es stated.

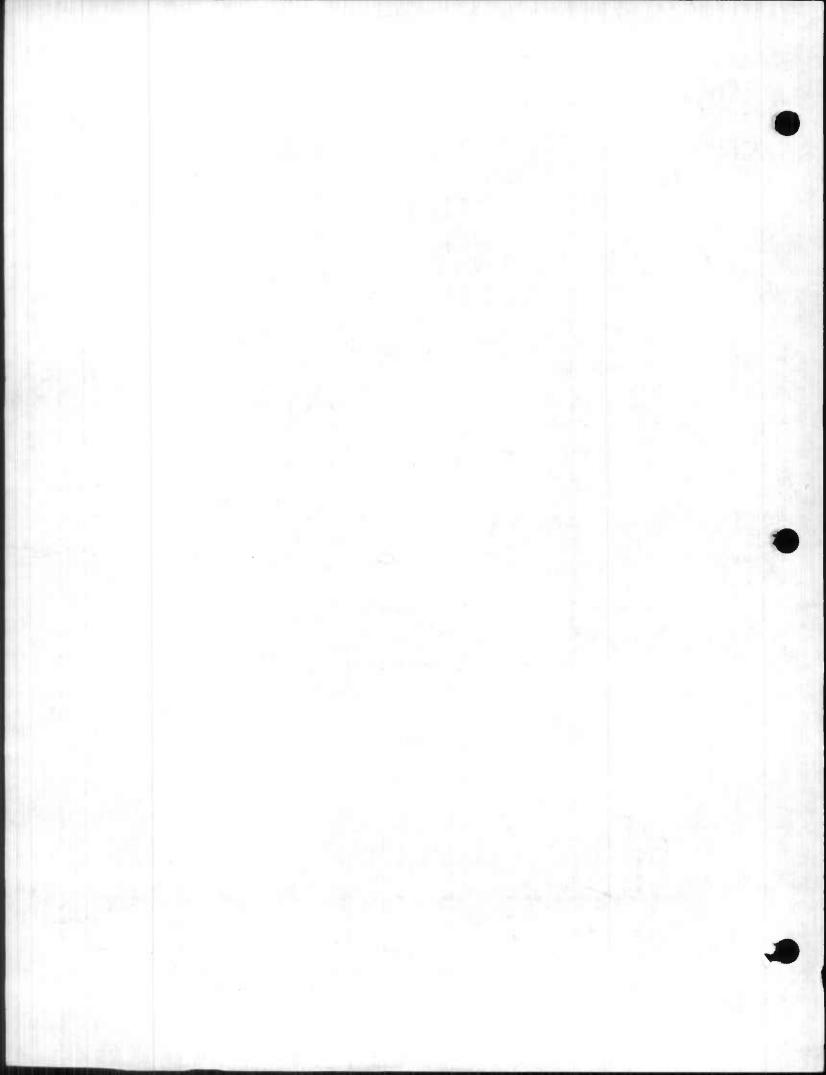
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the tima, data and placa, and dua to the cause(s) and menner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 29b. Signeture and little of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 0 abla rip D0047707 30. Name and addrass of person who completed ceuse of deeth (Item 23a) (Type, Print) PABLA Laurel MD 20707 Avenue 13621 Baltimore 31. Dete liled (Month, Day, Year) DEC 2 8 2000 32, Registrar's Signeture State Registrar



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State of Maryland / Department of Health and Mental Hygiene 2 2 9 7 3

AMEND TIES	1: #23A PARI I HER HIY G/91 I-II-2	OU WR. CO	ertificate of Death		Reg. No.	
Physicia:				2. Dete of Dec Month Novembe	oth Day Year	3. Time of Death
/Medica Examine	to Facility Name (Mant Institution also street and symb	spital Inc.	4b. City, To Cheste	wn, or Location of Death rtown	4c. County of Deat Kent	h
Funeral Director	5. Social Security Number  058-26-6856  058-26-6856  058-26-6856  058-26-6856  058-26-6856	Age (In yrs. last birthda 69 Yrs.	y) If Under 1 Year If Under Months Days Hours	Min. 8. Dete of Birt (Month, Da July 24	9. Birt 7, Year) 9. Birt	hplace (State or Foreign unity) JSA, New York
how how	10a. Stete 10b. County	10c. City, Town or				10d. Inside City Limits
See Ca	Mary land   Kent	Better				1 ☑ Yes 2 ☐ No
		Park.	10f. Zip Code 21610		10g. Citizen of What Co USA	untry?
020	11. Meritel Status  1 Never Married 2 Merrled  3 Widowed 4 Divorced  12. Was Decede Armed Force 1 Yes, Give Yeer or Dete	S? XNo	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar     □ Yes 2 No Specify:	n, Puerto Rican, etc.)	14. Raca - Ame Black, White Specify: Whi	e, etc.
72 ho	15. Decedent's Education (Specify only highest grade completed)	16a. Dec (Gr	pedent's Usual Occupation we kind of work done during mos . DO NOT use retired)	t of working	16b. Kind of Business/	Industry
121	Elementery/Secondary (0-12) College (1-4)	or 5+)	DO NOT use retired)		Home	
D The H	17. Father's Name (First, Middle, Last)	1100.		er's Name (First, Middle,		
E serial	Benjamin Schachter			ietta Ober		
Shou man	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street and Number			Zip Code)
N Sala	Stephen E. Leonard (Sc	n) 1982	26 Blue Heron L	ane Hagerst	own, Maryla	and 21742
Baltimore, smil. Pages 1 a Aparment of Hs my lejury or othe bos.	20e. Method of Disposition  1 ⊠ Buriel 2 □ Cremation 3 □ Removel from Ste 4 □ Donation 5 □ Other (Specify)	916	position (Name of rematory or other place)  National Ceme	Dete	20c. Location - City or	Town, State
Ball permit. Departr Imports any inj	21. Signature of Funeral Service Licanius		22. Name and Address of Facilities   Facilities   Pacilities   Facilities   Facilit	bein & Newn	nan Funeral Maryland	Home, P.A. 21620
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each limmediate Cause (Finel disease or condition resulting in death)  HYPER	Due to (or es a cons RIENSION	Chmis	Hemor	1	Initerval Between Onset end Deeth
	Cause (Disease or injury that initieled events resulting in death) Last	Due to (or es a cons				Yours
death ce attendi	Part II. Other significant conditions contributing to the	h but not resulting in the	underlying cause given in Part I	1. 23b. Did	tobacco use contribute	to the cause of death?
E XO.	Part II. Other significant conditions contributing to plant				Yes 20 No 3□P	robably 4 Unknown
aw requir					rmed?	Were eutopsy findings evallable prior to completion of cause of death?
yeiclen: The ly yeiclen: The list certificate he director, pege				10	Yes 2 THO	1 ☐ Yes 2 ☐ No
Of Vital I Physician: The this certificate ral director, peg	25. Wes case referred to medical examiner?		Othor	e of Death (Check only o		
0 5 5 7	1 Yes 2UMO 1 LEMP		of 28c. Injury et		dence 6 LOther (Spe how Injury occurred	cify)
DIVISION C tail or Attending P as after death. The Director: After to led in by the funers	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of building.	Injury - At home, farm, etc. (Specify)	street, factory, offica	28f. Location ( City or To	Street and Number or R wn, State)	ural Route Number,
DIVI To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by		s of examination end/or				
Withir To th comp			29c. License number		29d. Date signed (Mont	th, Day, Year)
	Leone M yo	una,	MD D319;	79	11/29/	83
	30. Name and address of person who completed cause of GEORGE M. NO.	of death (Item 23a) (Typ	1-0 2110	BTOWN	MA	21620
State Registra	31. Date filed (Month, Day, Year) 32. Reg	istrer's Signature	Spark			



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth DECEMBER 27, 2000 CHARLES NORMAN MATTHEWS 10:04 AM 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth PRINCE GEORGE HOSPITAL PRINCE GEORGE CHEVERLY 5 Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. lest birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Hours 1₩ M 2□ F Months Deys Yrs. 220-28-7061 MARCH 4, 1935 MARYLAND Usuel Residence of Decedent 10c City Town or Location 10b. County 10d Inside City Limits MARYLAND PRINCE GEORGE CAPITOL HEIGHTS 1 XYes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 502 PEPPER MILL DRIVE 20743 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1□ Yes 2⊠No Specify: Specify: BLACK 3 ₩idowed 4 Divorced 16e. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) COVERNMENT Elementary/Secondary (0-12) 12th College (1-4or 5+) MECHANICAL ENGINEER NAVAL LAB 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) JOHN MATTHEWS ESTELLA SHELTON MATTHEWS 19e. Informent's Name/Relationship (Type, Print) DAUGHTER 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) CONSUELLO DUNNINGTON 502 PEPPER MILL DRIVE CAPITOL HEIGHTS, MD 20743 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete ZION BAPTIST CHURCH CEM 12/30/00 WELCOME, MARYLAND 4 Donation 5 Other (Specify) 21. Somiture of Funeral Service Licensia THORNTON JOHNSON M00583 22. Name end Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset end Death Concer Immediate Ceuse (Finel disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did topacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy 2 No 1 Yes 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

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r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

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permit. Page Department of important: if any injury or once.

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Examiner Physician/Medical 88 à Completed pege 2 director. Be P Certification:

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P.O. Box 68760 certificata be Records. Division of Vital Hospital or Attending Physicien: 24 hours after deeth. Funeral Director: After this certifica funaral 3

Registrar

25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2011 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide

> Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
>
> | Medical Experience: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and stile

29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

WENDELL PIERSON, M.D. CHEVERLY, MD 3001 HOSPITAL DRIVE 20785

32. Registrar's Signature 31. Dete filed (Month, Day, Year) JAN 0 2 2001

24 hours

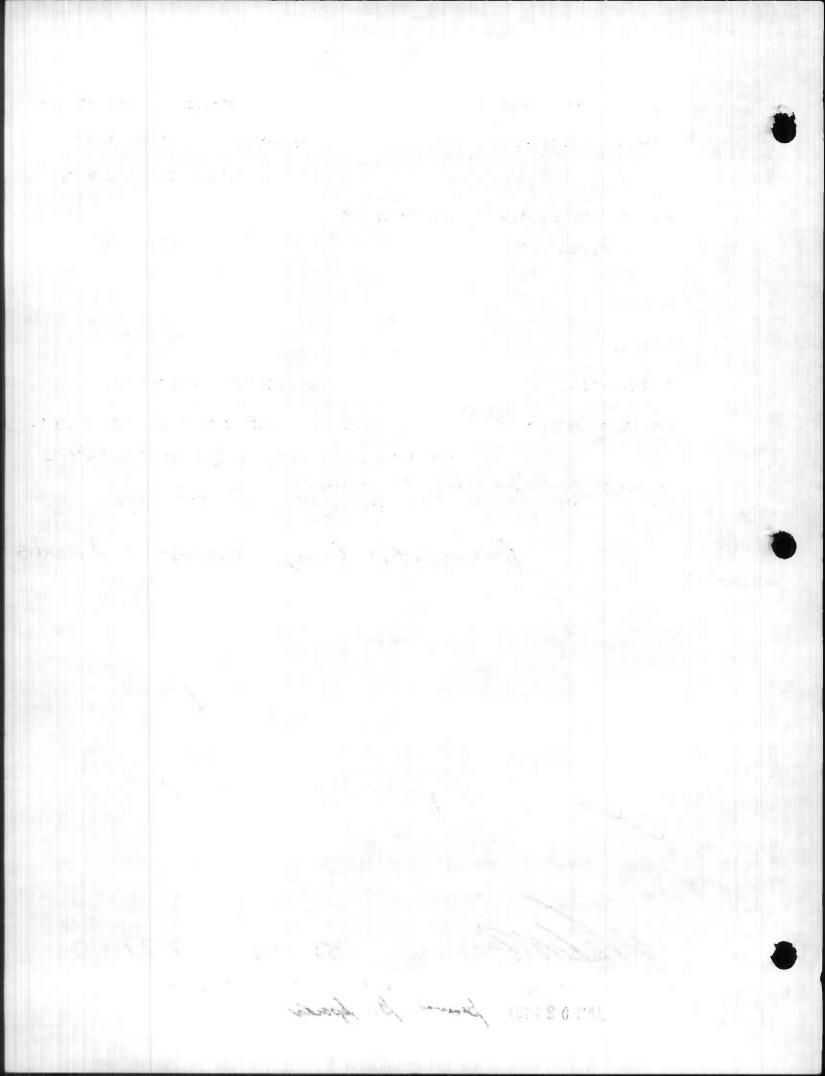
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29a. Certifier

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Physician /Medical Examiner The law requires that the death certificate be executed Box 68760,

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2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and menner stated. 29d. Dafa signed (Month, Day, Year) 29b. Signature end title of certifier 29c. Licansa number

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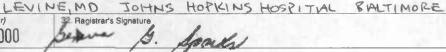
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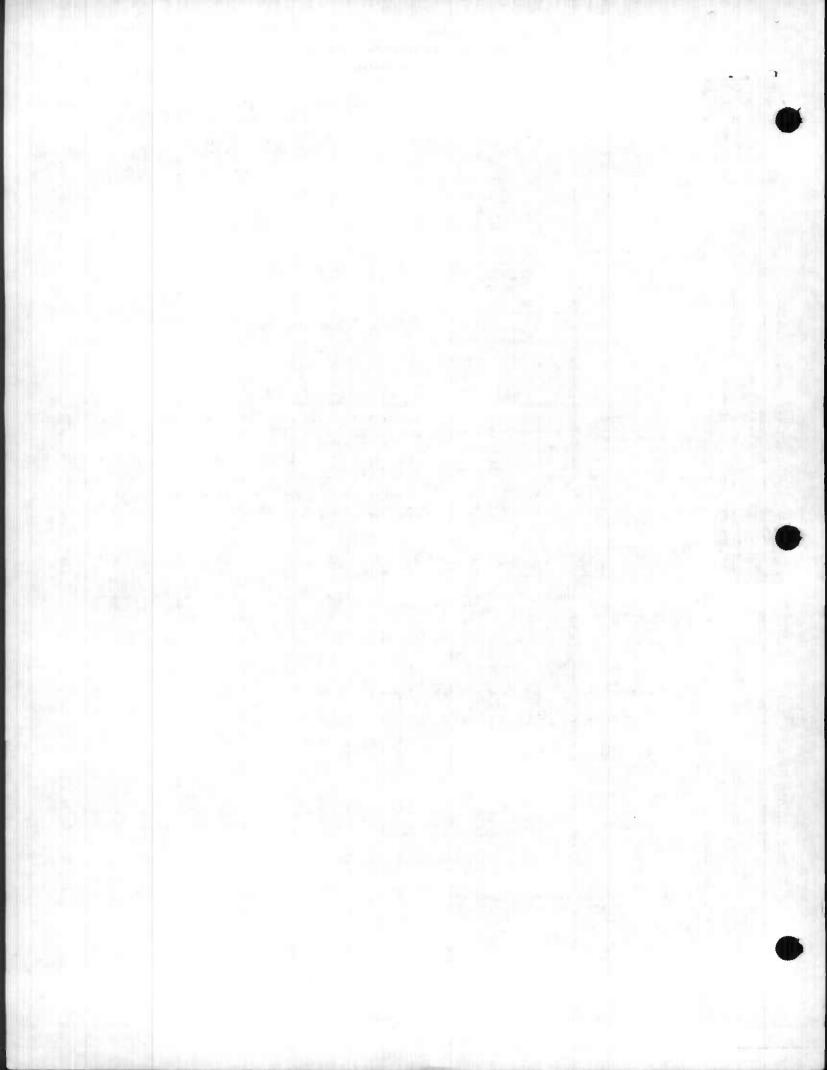
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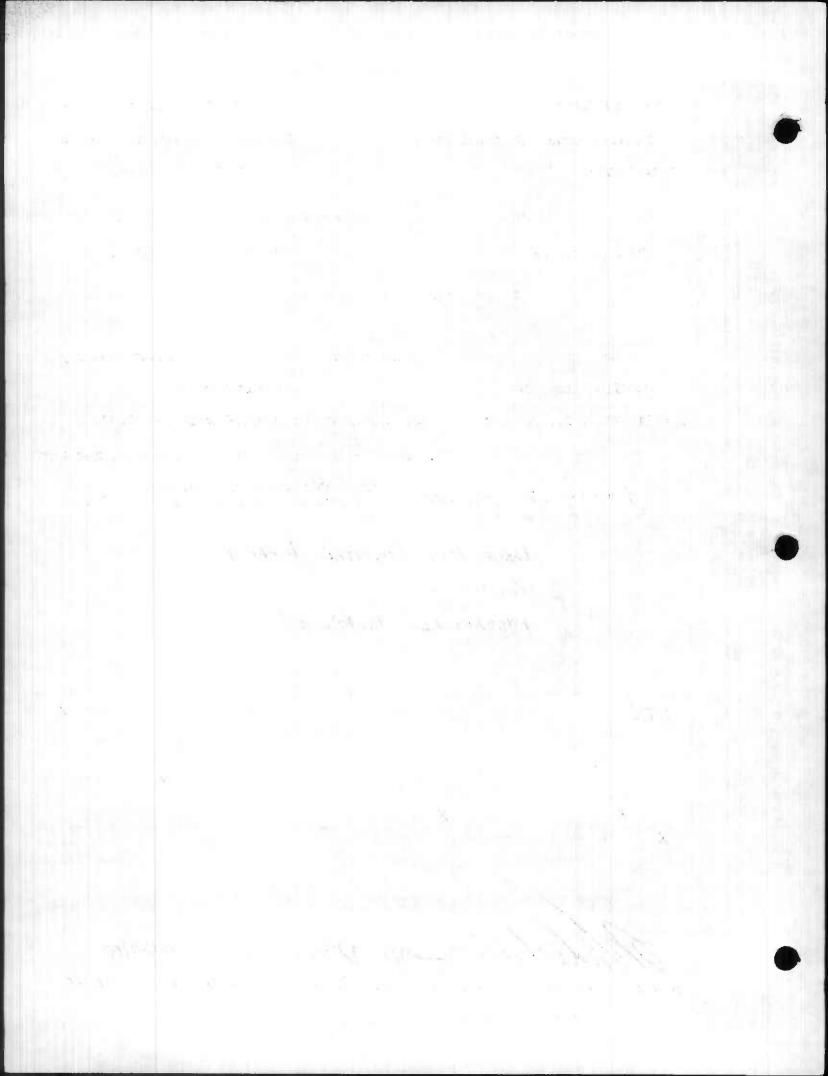


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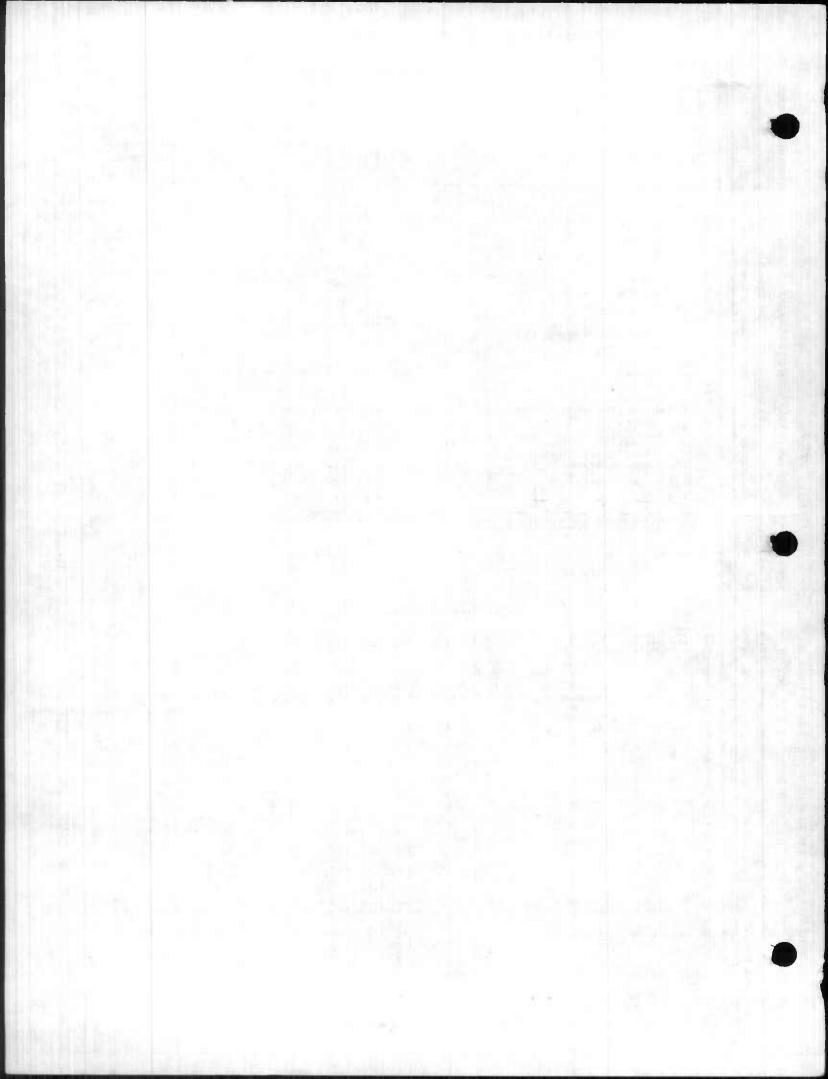
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uneral frector	5. Social Security Number 579–34–0737			Age (In yrs.	lest birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day 1 0 / 7 / 2	Year)		lace (Stete or try) h.,D.C	
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To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2 Medical Certification: To Be Comp		ertifying Physicia edical Examtner:		s of examina									)
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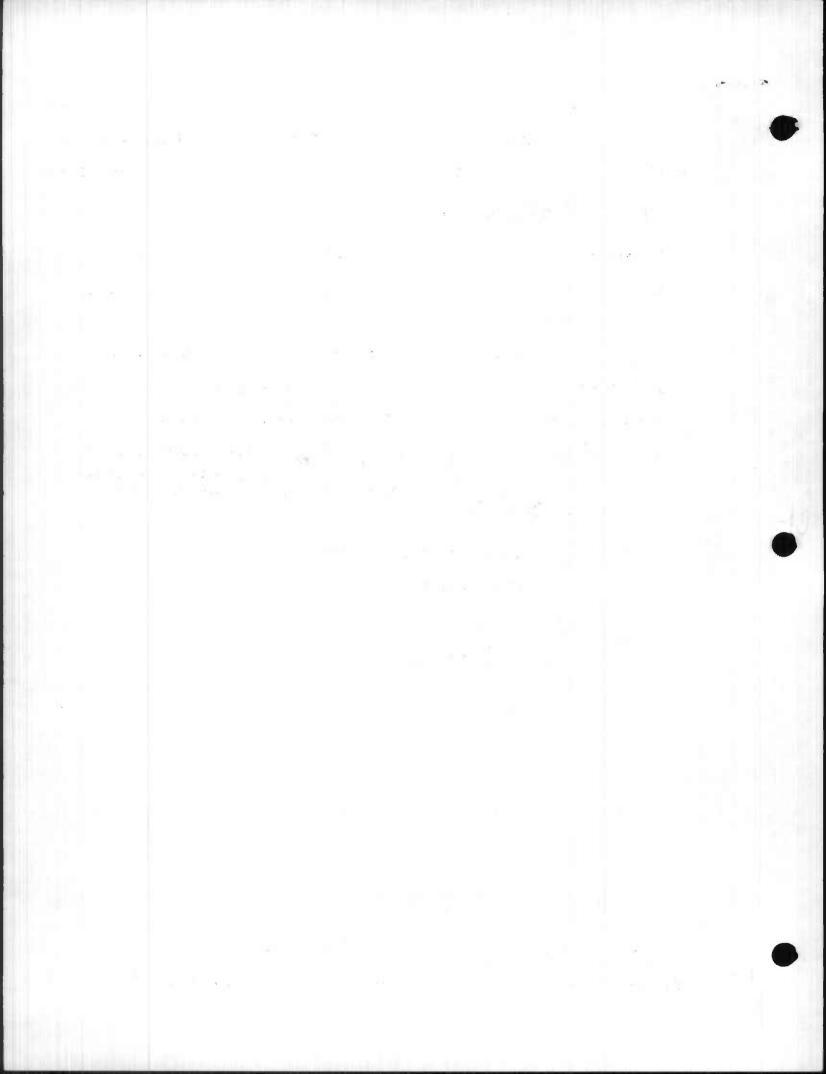
State of Maryland / Department of Health and Mental Hygiene

Cartificate of Death

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Fune	ral	5. Social Security Number	6. Sex	χM 2□ F	7. Age (In yr 80		Mont	ths Deys	If Unde Hours	Min.	8. Dete of Bi (Month, De	rth ey, Yeer)	9. Birthp	leca (Stete or Fo	oreign
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Maryland 21215-0020 of 2 should be find within 72 hours aff the and Merial Hygiene. The marked other then "natural", or treatments arent the Medical Example.	o Be	Renix B. Mil								Eliza		Drap			
hould by d Menta	F	19a. Informent's Name/Relation	nehin /Tv	ne Print)		19h A	AbA poilie	Irass /Straat	end Num	her or Rur	al Route Numl	per, City or Town	State Zir	Code)	
Mar md 2 sh aith and 27 is my		Dennis Mill				1						Kansas		,	
0 5 - 11		20e. Method of Disposition				Plece of C	Disposition (	(Neme of		1	Date	20c. Location		own, State	
Baltimore, emit. Pages t ar apportunent of Hear myortanti, if Hear 3		1 Buriel 2 Cremetion 4 Donation 5 Other (		emoval from				or other ple		2, 20	00	Clinto	n Ma	ryland	
in a state of the		21. Signeture of Funerel Service		99		ee CI		e end Addre						633 Old	
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£ 1000	-	23a. Part1. Enter the diseese, of	or compli	cations thet	aused the de									Approximete interval Between	
Physicia	an	shock, or heart teilure. Lis	st only or	ie cause on e	ech iine.								1	Onset end Dea	ath
/Medic	_	Immediate Cause (Final disease or condition		I	Arterio	olosci	Leroti	ic Car	diova	ascul	ar Dis	ease	1	Years	5
9 Examin		resulting in deeth)	е		Due to	(or es e co	nsequenca	of):							
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60, be executed citan and burial-transit	Examiner	Sequentially list conditions, if eny, leading to immediate			Due to	(or es a co	nsequence	of):				Marin La			
38760, cate be exphysician		Cause (Disease or Injury	2 .	)										CONTROL	
X & a se	2	thet initieted events resulting in deeth) Last	1		Due to	(or es e co	nsequence	of):					İ		
M ~ E E	_ ≥		L .	1											
P.O. Box hat the death centre detailed for used	Physician/	Pert II. Other significant condit	lone con	tributing to d	anth but not r	neulting in t	ha undarkii	ina causa ci	uon in Por	+ 1	23h Die	I tohacco usa c	ontribute t	o the cause of d	death?
	hys		MOVIE COL	ithoung to o	baill but not i	esonary are	no underly	ing cause gr	voi: iii r oi					bably 4∭Un	
S, P	by P	Dementia													
10 = 00	8	Diabetes									24e. We	s en autopsy lormed?	24b. W	ere eutopsy find aileble prior to	lings
() - 00	plet	Dianeces									Poli	omou,	CC	mpletion of caused deeth?	se
I Re lev		Se paraller									10	Yes 20 No	11	Yes 20 No	3
	9	25. Wes case referred to medic	al						26. Pla	ce of Deet	th (Check only	one)			
		examiner? 1 ☐ Yes 2 ☒ No	Н	lospitel:	Inpatient 2	☐ ER/Outp	petient 3	DOA OI	her: 4 🗆 N	Nursing Ho	ome 5 Res	sidenca 6 🗆 O	ther (Speci	(y)	
		27. Manner of Death 1 ☑ Naturel 5 ☐ Pend	lina	28a. Date (Mon	of Injury th, Dey Year)	28b. Tir		28c. Inju Wo	ry at		28d. Describe	how Injury occ	urred		
Vision Attending or death.	Satio	2 Accident inves	tigation				М	1	Yes 2[	□ No					
Division  Tor Attending after death.  To Attending	Certification:	3 Suicide 6 Could deter	mined	28e. Place build	of Injury - Aling, etc. (Spe	t home, fern	n, street, fa	ctory, office			28f. Location City or To	(Street and Nur own, Stete)	nber or Run	el Route Numbe	4.
Divisi Divisi Hospital or Attent 24 hours after deat Funeral Director:			21-720												
Hoep Et ho				ner: On the b	asis of exami							e ceuse(s) and r e, dete end plece			
To the Hospital Within 24 hours Within 24 hours Completely filled	Med	29b. Signeture and title of control	91	ena man	ner steted.			29c. Licen:	se number	r		29d. Date sign	ed (Month.	Dey, Year)	
F3F8		DIA!	h		17.1	7	10		05	- 11					)
7	1	20 Northand Street		malated as	no of death th	lam 00-1 /	ime Delet	10 -		, ,		Dece	iner a	22, 2000	,
(2)	)	30. Neme and eddress of person													
	State	Joel Schulma 31. Dete filed (Month, Dey, Year	r)		legistrer's Sig	nature,	.d_Gec	orgeto	wn_Ro	oad B	ethesda	a Maryla	and 20	)814	
	istrar	DEC 2 7 20	000	Sen	wa	B.	die	ala							



	Donadontia Non-	/Eight Adid-Mc	( ant)		Ce	rtificat	e or	Death		2 Date		J. Nd.	4	7 Time of Dooth
cian	Vester	(First, Middle, Mayo	Last)							2. Date Mont		Day 22 20	Year	3. Time of Death
lical iner 48	a Facility Name (If		give street end n	um <i>ber)</i>				4b. City, To	wn, or Lo			4c. County		20 111
	Prince Ge	orge Ho	spital					Cheve	rly,	MD		Prince	Georg	e's
	Social Security Nu		Sex 1□ M 2□XF	7. Age (In yrs	. lest birthday)	If Under	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Dafe (Mon	of Birth	reer)	9. Birthplac	e (Stete or Foreign
	02-42-101		1 M 2 LA	50	Yrs.		,			2-1-				Carolina
-	suat Residence of I 0a. State	10b. County		10c. C	ity, Town or Lo	ocation			-			Call	10d.	Inside City Limits
0	MD	Prince	George'	s Lan	dover									Yes 2 No
runeral Director	0e. Street end Num	ber				10f. Zip	Code				109	g. Citizen of \	Whef Country	?
	3200 Amad	or Driv	7e			2.0	785					U.S.	Α.	
1	1. Marital Status		12. Wes De	cedent Ever in I	J,S. 13.	Was Dece	dent of H	lispanic Ori an, Mexicar	igin? (Sp	ecify Yes	or No-		a - American ck, White, etc	
	1 ☐ Never Marrie 3 ☐ Widowed 4			2 <b>∑</b> No Sive		1 ☐ Yes				riioari, or	o.,	Specify		
	(Specif	15. Decedent's	Education grade completed	n	16a. Dece	dent's Usu	el Occup	oation during mos	t of work	ina	10	6b. Kind of B	usiness/Indus	try
-	Elementary/Secon			(1-4or 5+)	life.	DO NOT u	se retire	d)	. o. work					
	7 Catho to bi	Time & 62-4-4	2yrs			Nur	se	10 11-11	ada NI	o /First 1		overnm		
1	7. Fether's Name (F		ist)								nodle, Mi	eiden Sumen	10/	
-	Roy Allen		/Tuna Brist		105 14579	no Addres	a 100mm	Loren		2	himbar	City or Taur	State 7in C	ode)
	9e. Informent's Nar Lorenza L											untain	Stete, Zip Co	700)
-	De. Method of Dispo		HOUNET	20b.	Place of Dispo	osition (Ne	me of			Date	-		- City or Town	, Stete
	1 ₽ Burial 2 □	Cremation 3		n State	cemetery, cre	matory or	other ple		Carl				er, N.C	
2	4 Donation 5			l'ye	d Hill					R. To	nkin	s Fine	ral Ho	me
	21. Signature of Euleran Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785													
1 2	23a. Part1. Enter the shock, or heart	disease, or o	mplications that	caused the dec									A	pproximate terval Between
cal Examiner	mmediate Ceuse (F. isease or condition esutting in death)  Sequentially list con- any, leading to imr ause. Enter Under ause (Disease or ir at initieted events soulting in death) L.	ditions, nediate ying ijury	,	Due to VAL	or as a conse	quence of) QUE quence of) RE	$\epsilon$							
5			d. HY	PERTE	ENSIDI	N								
Physician/M	art II. Other signific	ant condition	contributing to	death but not re	sulting in the u	underlying	cause gir	ven in Part	f.	23t	. Did tob	acco use co	ontribute to the	ne cause of death?
											1 🗆 Ye	a 2□No	3 Probai	oly 4 Unknow
-										24a	. Wes en perform	eutopsy ed?	eveile	eutopsy findings able prior to eletion of cause ath?
on boundary											1 🗆 Yes	2XN0	101	res 2□ No
2	5. Was case referre	ed to medical						26. Place	e of Deat	h (Check	only one	)		
2	1 ☐ Yes 2 N	lo			☐ ER/Outpatie		UA		ursing Ho			ica 6 □Ott		
	7. Manner of Death 1. Natural 2 Accident	5 Pending Investiga	tion	e of Injury onth, Dey Year)	28b. Time of injury	of M	28c. Inju Wo 1 □	ry et rk? ] Yes 2 □	No	28d. Des	cribe hov	v injury occur	red	
2 Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	f be ed 28e. Pla buil	ca of Injury - Af I ding, etc. (Spec	home, farm, st	reet, factor	y, office			28f. Loca City	ition (Stre or Town,	eet end Num Stete)	ber or Rural F	Route Number,
			Physician: To the aminar: On the and ma											
	9b. Signature and ti	itle of certifier	1			29	c. Licen:	se number				_	ed (Month, De	
	1/1/	V	NO				D4	366	2			12/2	7/00	
	0. Name and address	0 . 1	no completed ca	use of death (ite	m 23a) (Type,	Print)	N	DIVE		1	1010	DIV I	17/00 Md 3	0785
	NILLIAM	DOYCE,	MID	0007	TIWITI	INT	201	.710		4	reve	KLI,	10	0100



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day **Physician** 4:00 AM SHIRLEY DELORES MOULDEN DIEEMBER 27 2000 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Doctors Hospital Lanham Prince Georges If Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Hours 1□M 2☑F Months Deys Yrs 218-34-5142 63 Director 12-6-37 Bowie, MD Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Yes 2 No Director Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or flams 23s or traumstic event, the Medical Examinar must be 12106 Lanham Severn Rd. 20720 U.S.A death Funeral 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2√ No Specify: Specify: Black by 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12th Building Supervisor Government permit. Pages 1 and 2 should be file Department of Health and Mental Hyg important: If Item 27 is marked other any injury or other traumete. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Guy Luke Hawkins Margaret H. Hawkins 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Bernetta V. Smith/Daughter 12106 Lanham Severn Rd., Bowie, MD 20720 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 XBuriel 2 Cremetion 3 Removel from Stete 4 □ Donetion | 5 □ Other (Specify) 1/03/01 Clinton, Maryland Resurrection Cemetery 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility J.B. Jenkins Funeral Home 7474 Landover Rd., Landover, MD 20785 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervei Betw Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) wills Examiner Examine Myo Cardia 3 Louis physician and the burial-transit death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Box 68760, Physician/Medical attending p for use as signed by the a d be detached f Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, p 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was en autopsy performed? is certificata has t Vascu 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicet exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 2 1 Inpatient 2 ER/Outpetlent 3 DOA 27. Menner of Death 28a. Dete of tnjury (Month, Dey Year) 28c. Injury et Work? 26d. Describe how injury occurred Certification: Hospital or Attending 24 hours after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined To the Hospital or To the Funeral Direct 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end mennar as stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner steted. 29a. Certifier Medical

MOULDER

State Registrar 29b. Signeture end title of certified

HEMA

31. Dete filed (Month, Day, Year) 32 Registrar's Signeture DEC 2 8 2000

m.D

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

YADLA

9470

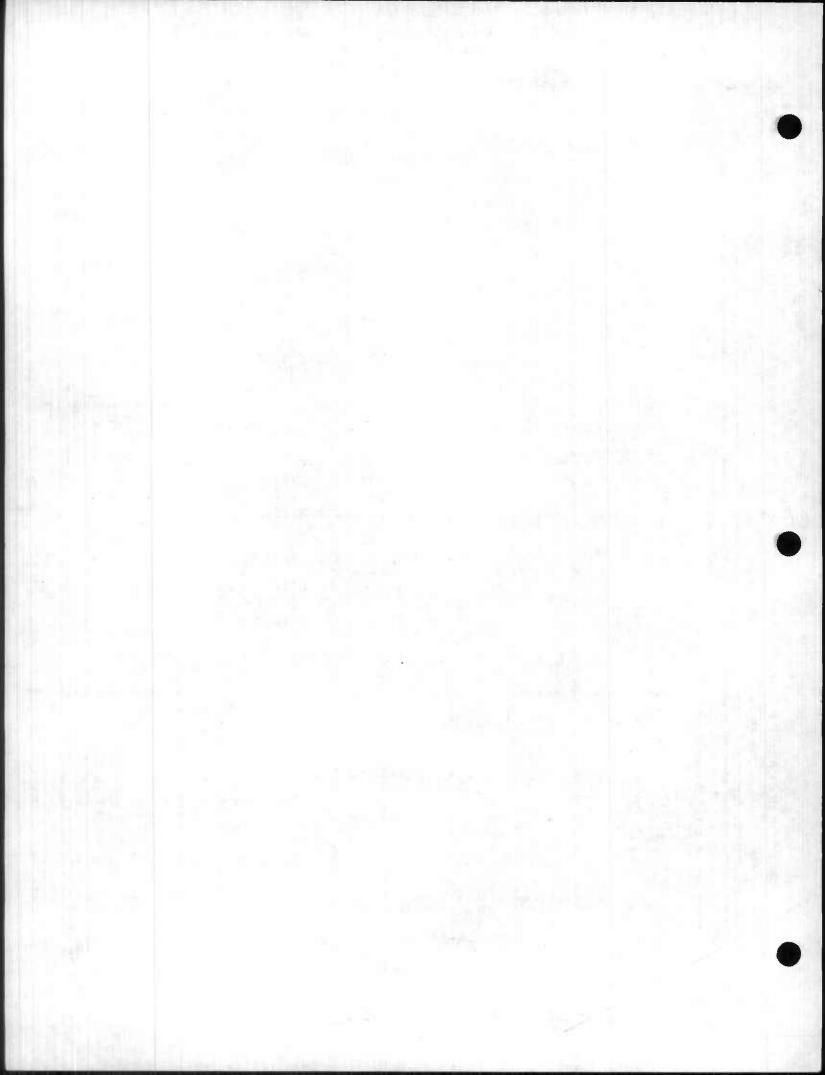
29c. License number

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ANNAPOLISRA,

29d. Dete signed (Month, Dey, Year)

00

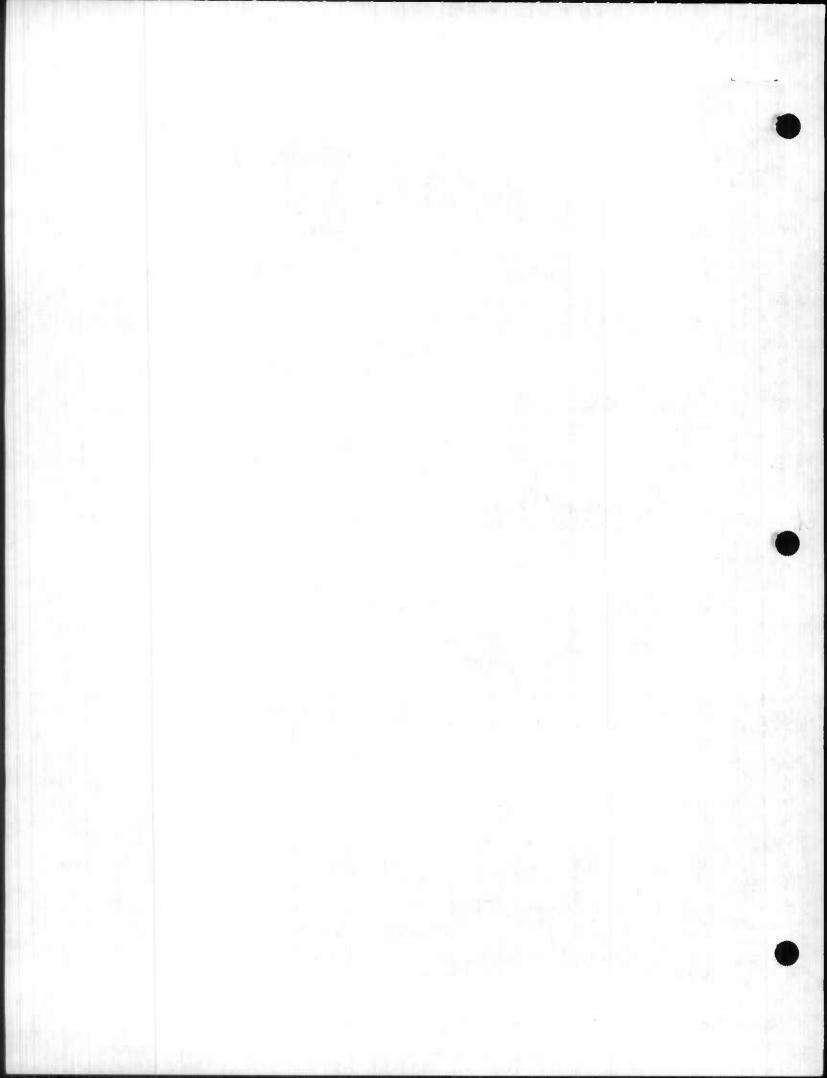


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No 0 4 2 9 8 6

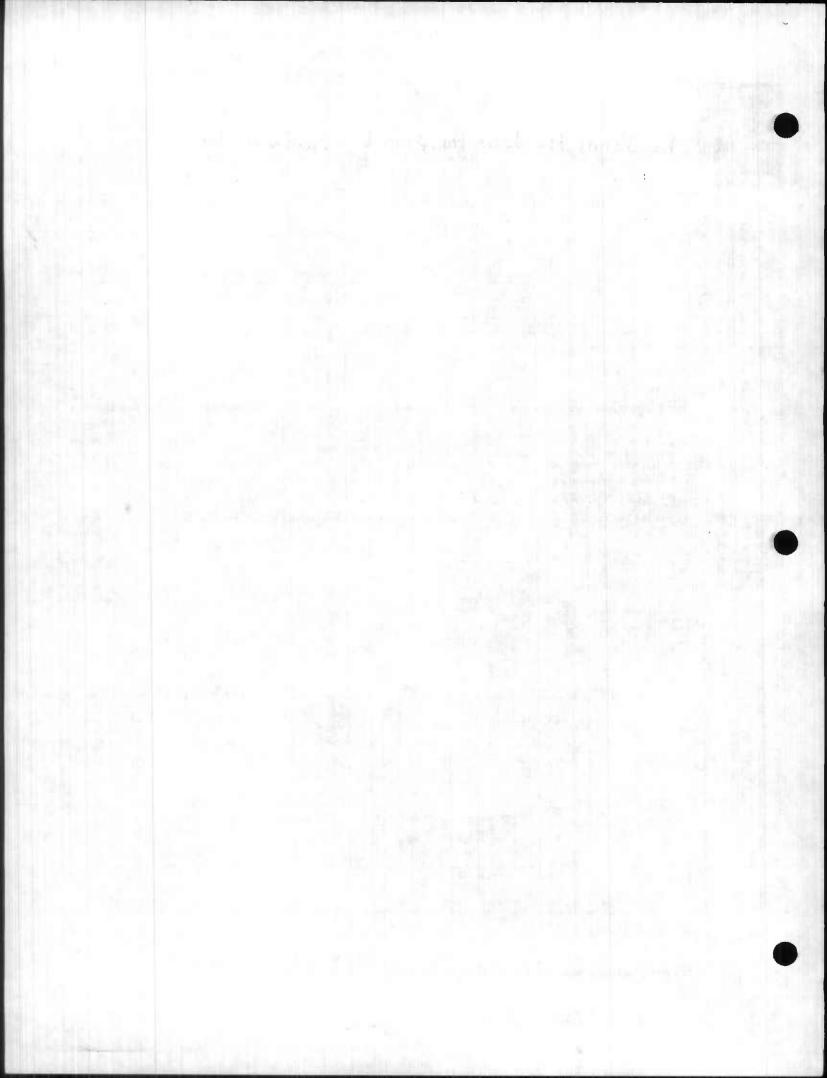
2				Ce	rtificate of	Death	R	eg. No.	473	00
		1. Decedani's Nama (First, Middle, Las	1)				2. Dale of Deel			ne of Death
	hysician /Modiael	Mary Milner	22,2000	B:00	) P.M.					
3	/Medical xaminer	4a Facility Name (If not Institution, giva 1398 Rollinghouse				4b. City, Town, or Frederic	Location of Death	4c. County of		
	neral ector	417 12 1005	7. Age (In	yrs. last birthdey) 89 Yrs.	Months Days		(Month, Day,	Year) 23,1911	9. Birthplece (S Country) L Pennsy	tate or Foreign ylvania
put	*	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Le	ocalion				10d. Insi	da City Limits
Aaryle	or or		T.	rederick						Yas 2 No
the state of	Tect not	Maryland Frederick	F	rederick	10f. Zip Code		1	0g. Citizan of Wh		Λ
with		1398 Rollinghouse	Drive		217	03		U.S.A.		
	is, or tems 23s of 25s-1 show transfer must be notified at by Funeral Director	11. Marital Sletus  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1   Yes 22 No If Yes, Give Yeer or Dales:		Was Decedent of If Yas, specify Cul	Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or No- to Rican, alc.)	Black,	Amarican India Whita, etc.	an,
Maryiand 21215-0020 d 2 should be filed within 72 hours at this and Mental Hygians.	deal Eve	15. Decedeni's Edu		16e Dace	dent's Usual Occu	pallon		16b. Kind of Busi		
5 m		(Specify only highest grad	de completed)	(Give	kind of work done DO NOT use retir	e during most of wo	orking			
d 2121 filed within Hygiana.	dwo.	Elamentary/Secondery (0-12)	Collega (1-4or 5+)	Homem	naker			Own Home	2	
laryiand 2 should be filed and Mental Hygi	marked other than imatic svent, the to To Be Comp	17. Falhar's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, M	Maiden Sumame,	)	
aryian should b	To F	Milton Crouse				Mae She	earer			
2 she and	# # #	19a. Informani's Name/Relationship (T	ype, Print)	19b. Maili	ing Address (Stree	et and Number or R	ural Route Number	, City or Town, S	tate, Zip Code)	
	N L	Judith N. Koch / D				ouse Dr.	Frederic			
imol Fages	Intury or other	20a. Mathod of Disposition  1 Buriel 2 Cremation 3 I  4 Donetion 5 Other (Specify,	Removal from Stale		matory or other pl		Dale	20c. Location - C 000 Brer		
Baitin Pemit Pa	ni kun	21. Signature of Funeral Service Licens	Theres		2. Name and Add	r	t. Lincol d. Brentw			
		23a. Part1. Enler the disease, or comp shock, or heart la lure. List only of	lications that causad the	daath. Do not en	tar the mode of dy	ring, such as cardia	c or raspirelory erro	esi,	Interva	ximate al Between
Physi /Med Exam	dical	Immediate Causa (Final disease or condition rasulting in daath)		ell Lung					2 Mor	and Death
T P	e e									
Box 68760, death certificate be assecuted	ng prysician and it as the burlet-transit	Sequentially list conditions, if eny, leading to immadiate cause. Enter Undarlying Cause (Disaase or injury that initialed events rasulting in deeth) Last	С.	to (or as a consecto (or es a consec						
Box ath cert	for usa a		d							
co the state of	od for	Pert II. Other significant conditions co	ntributing to death but no	ol resulting in tha	underlying ceuse o	iven in Part I.	23b. Did to	bacco use cont	ributs to the ca	use of death?
2 3	be detached for use by Physician/	Chronic Obstruc					1 <u>₩</u> Y	es 2□ No	3 Probably	4 🗌 Unknown
requir	2 should						24e. Wes e perform	n eulopsy med?	24b. Were euto available completio of deeth?	
T all	Paga						1 🗆 Y	es 2 No	1 🗆 Yes	2 No
	rector, par rector, par rector, par	25. Was cese referred to medicel examiner?				26. Placa of De	eth (Check only or	ne)		
O the	T di	1 Yes XXNo  27. Manner of Deeth XXNatural 5 Pending 2 Accident investigation	Hospital: 1 Inpalient 28a. Date of Injury (Month, Day Ye	2 ER/Oulpatie 28b. Time of Injury	of 28c. Inj		Home 5 🖾 Raside	ence 6 Other		
> A P	ed in by the funare Certification:	3 Suicide 6 Could not be datarmined	28e. Place of Injury - building, etc. (S	At home, farm, sl pecify)	reel, factory, office	ð	28f. Location (Si City or Town	treet end Number n, State)	r or Rurel Route	Number,
To the Hospital o	plataly fills	29a. Certifier XIX Certifying Phy (Check only const) 26 Medical Exami	reician: To the best of my iner: On the basis of exa and pranner stated.	y knowledga, deal mination end/or in	h occurred at the nvastigation, in my	time, date end plac opinion, daath occ	e, end due to tha c surred el the lime, d	euse(s) and man late end plece, ar	ner as stated. nd due to lhe ca	iusa(s)
T V V	<b>≥</b>	29b. Signatore and the of cartifie	1/1/			nse number	1 2	9d. Dele signed	(Month, Day, Y	ear)
E	)	30. Nama and addrass of person who b	ompleted cause of death	(Kem 23a) (Type	Do (	05240		ecembe	r 23,	2000
_0	/	Thomas M. Annulis	м.р. 1112	O New Ha	mpshire	Ave. #305	; Silver	Spring,	MD 209	904
B	State	31. Date filed (Month, Dey, Year) DFC 2. 8 2000	32 Registrer's	Signeture	land					



State of Maryland / Department of Health and Mental Hygiene 0 4298 |

				Certifica	ate of	Death		Reg. No.	14 C	201
	1. Decedent's Name (First, Middle, Li	est)			-	A SE ES	2. Date of De Month	ath Day	Year 3	3. Time of Death
ician dical	GRACE			NEWK	IRK		DECEMBE			05:05
niner	4a Facility Name (If not institution, gir	ve street and number)	1.1	.1 .		4b. City, Town, or	Location of Death	4c. County	of Death	
	The Johns +	opkins	Hos	pital		Baltimo	re City			
ı			(In yrs. last	birthday) If Und	der 1 Year		8. Date of Bin	h Vear)	9. Birthplace Country)	e (State or Foreign
	108-34-6621	1□M 2⊠F	53	Yrs.	Days	110013	May 1,	1947	Florida	a
	Usual Residence of Decedent									
	10a. State 10b. County			wn or Location						Inside City Limits
Director	Florida   Martin	11,270,15	India	n Town					2	X □ Yes 2 □ No
II D	10e. Street and Number			10f. 2	Zip Code			10g. Citizen of V	What Country?	?
runeral L	14886 S.W. 174 Co	ourt West				34956		USA		
	11. Marital Status	12. Was Decedent E	ver in U,S.	13. Was Dec	cedent of I	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No	- 14. Rac	a - American I	
	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	0				to rican, etc.)		ck, White, etc.	
	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 Li Yes	2∏ No	Specify:		Specify	Black	
	15. Decedent's E		16	a. Decedent's U	sual Occur	pation		16b. Kind of B	vsiness/Indust	try
Compilered	(Specify only highest gr Elementery/Secondary (0-12)	ade completed)  College (1-4or 5+		life. DO NOT	work done	during most of wo	rking			
į	Liementery/Secondary (0-12)	2+	F	amily So	ervic	e Worker		Private		
	17. Father's Name (First, Middle, Last	)			- 1	18. Mother's Na	me (First, Middle,	Maiden Sumen	10)	
900	Jethro Golden					Beatric	e McNair			
-	19a. Interment's Name/Relationship	(Type Print)	11	9h Mailing Addre	es (Street	and Number or R	ural Route Numb	er City or Town	State Zin Co	rde)
						Drive Up				
	Lisa McNeil /daug	giiter					Date	20c. Location		
	1 Burial 2 ☐ Cremation 3	Removal from State		ot Disposition (A fery, crematory o						
	4 ☐ Donation 5 ☐ Other (Speci	fy)	Port	Mayaca			12-30-00	Port M	ayaca,	Florida
	21. Signature of Funeral Service Lice	psee / a /	11	22. Name	and Addre	ess of Facility Ma	rshall's	Funera	1 Home	of MD
	Juliar. IV	anner	V	4308	Suit1	and Road	Suitlar.	d, MD 2	0746	
	23a. Part1. Enter the disease, or con shock, or heart tailure. List only	plications that caused t	the death. D	o not enter the m	ode ot dyi	ng, such as cardia	c or respiretory a	rrest,	Ap	proximata terval Between
	Spock, or near tailore. List only	one cause on each line	<b>5</b> .							nset and Death
	Immediate Cause (Final	٨							-	
	disease or condition resulting in death)		osis		.43				13	PAYS
				a consequenca o	ot):				0	
		b. tunge		PSIS					10	DAYS
	Sequentially list conditions, if any, leading to Immediate		Due to (or as	a consequenca o	ot):					
	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
edica:	that initiated events resulting in death) Last	D	ue to (or as	a consequence o	f):					
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1	Part II. Other significant conditions	contributing to death but	t not resulting	In the underlying	g cause gi	ven in Part I.	23b. Dld	tobacco uas co	ntribute to the	s causs of death
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	2 Accident Investigation			М	1	Yes 2□No				
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injuit building, etc.	ry - At home,	farm, street, tact	ory, office		28f. Location ( City or To	Street and Numi wn, Stete)	ber or Rural R	oute Number.
		John Ig, etc.	(2000)					-,		
carcal cer micanon.		nysician: To the best of								
		miner: On the basis of e and manner stat	examination :							
	29b. Signature and title of certifier	0		1	29c. Licen	se number		29d. Date signe	d (Month, Day	y, Year)
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	Kichar A	Sellecte			KES	-000		DECEMBE	R 25,	7000
	30. Name and address of person who	completed cause of de	ath (Item 23a	(Type, Print)			A A			0.
	RICHARD A. ELLIOTT	GOU NORTH	WOLFE	STREET	R	9LTIMORE.	, MARY	LAND 2	1287-	- 4106
е	31. Date tiled (Month, Day, Year)	32 Registra	r's Signature	1. 1	1					
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DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

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	Physiciar /Medica		Louise	Nokes							2 2		2000 12:5	5 PM
- )	Examine		a Facility Neme (If n	ot institution, giv	e street and num	ber)			4b. City, Town,	or Location of D	eath 4c.	County of	Death	
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	Funeral Director		577-58-963	11.01	ex □M 2DXF	7. Age (In yrs. I 86	ast birthday Yrs.	Months De		Vin. (Month	Birth Day, Year) -1914		Birthplace (State Country)	
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21215-0020	an di	Dy Fur	1 Never Married 3 Widowed 4 [		Armed For 1   Yes If Yes, Give Year or Da	ces? 2 ☑ No		If Yes, specify C	of Hispanic Origin Juban, Mexican, P Jo Specify:	uerto Rican, etc.		Bleck,	White, etc. Black	
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	Physician		23a. Pert1 Enter the shook, or heert for	eilura. List only	one cause on as	ch line.	. 50 1101 01		3) 11 g; 000 1 00 00.	and or roop note	, , 5.1.001,		Interval Be Onset and	tween
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00			WIV	larry	Tract	ins	ect	ion		F	erformed?		aveilable prior completion of of death?	cause
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	Hospi 24 hour Funer stely fill	200	29a. Certifier (Check only 2[	Certifying Ph Medical Exan	ysician: To the base	is of examineti	viedge, deal on and/or in	h occurred at the	time, date end p y opinion, deeth o	lece, end dua to occurred et the ti	tha cause(s) me, date and	and mann pleca, end	nar as stated. d dua to the cause(	s)
	within To the comple	-	9b. Signeture end title	e of certifier				29c. Lice	ense number	11	29d. Dat	e signed (	Month, Day, Year)	
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	State	3	1. Dete filed (Month,	Day, Year)	32. Re	gistrer's Signat			7	- of a way		very	1)/-10 21	,,00
	Registrar		DEC 9	8 2000	he	war	4	1						

#### Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year MARY W. December 20, 2000 11:21 PM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Daath Southern Maryland Hospital Clinton Prince Georges 5. Social Security Number If Under 1 Year If Undar 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 XF Months Davs Hours Min Yrs. 579-09-1595 89 June 12, 1911 Tatum, S.C. Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 XYas 2 No D.C. N/A Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4325 DuBois Place S.E. 20019 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 yr Examiner Bureau of Engraving 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John H. Miles Louisa Bostic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Inez M. Day - Sister 4325 DuBois Place S.E., Washington DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cemetery12/27/00 Suitland, MD 22. Name and Address of Fecility Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4217 9th Street N.W. Washington DC 20011 23a. Fig. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dua to (or as a consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last / wells 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menger of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Demit. Pages 1 and 2 should be file Department of Health and Mental Hyg. Important: if them 27 is marked any injury or other them.

**Physician** /Medical

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Physician/M

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Certification:

29a. Certifier (Check only one)

2-20-00

Berwa

Director

Funeral

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To the Y

30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Laxmi Berwa, M.D. 31. Date filed (Month, Day, Year)

DEC 2 6 2000

29b. Signeture and the of certifier

7700 Old Branch Ave, Clinton MD 32. Registrar's Signatura

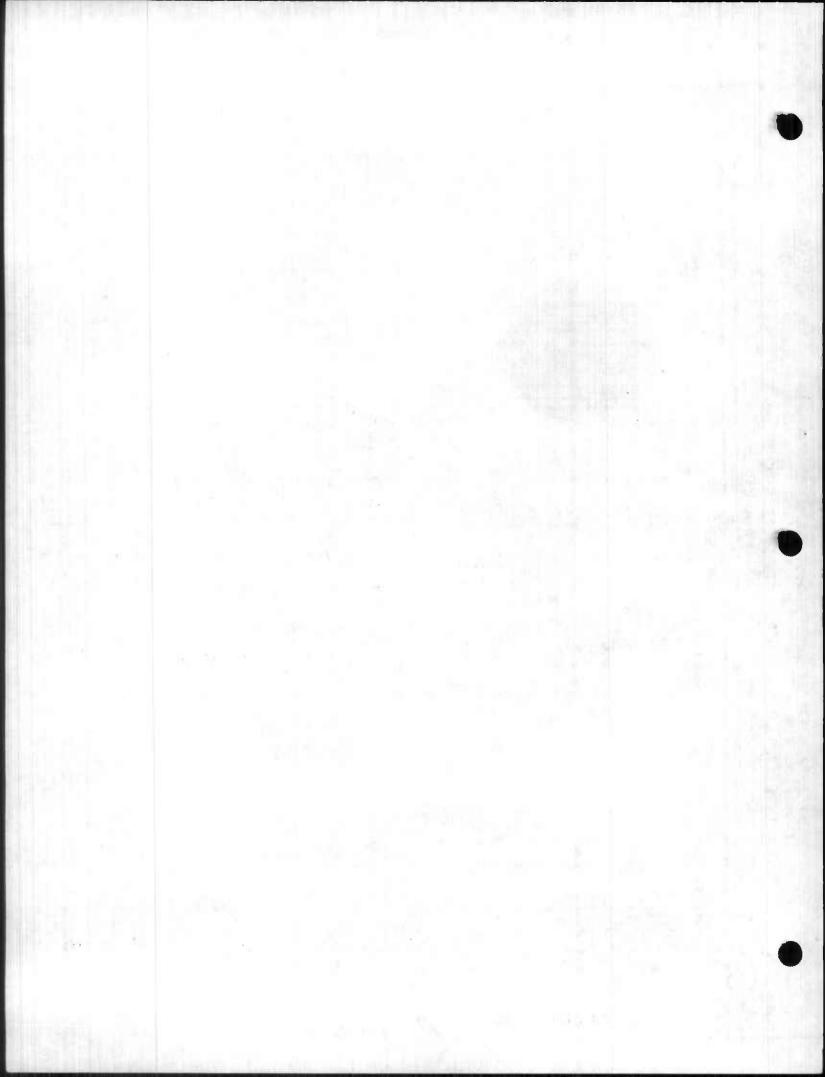
1♥ Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner as stated.
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

12.22.00

**DHMH 16 Rev 6/95** 

Registrar

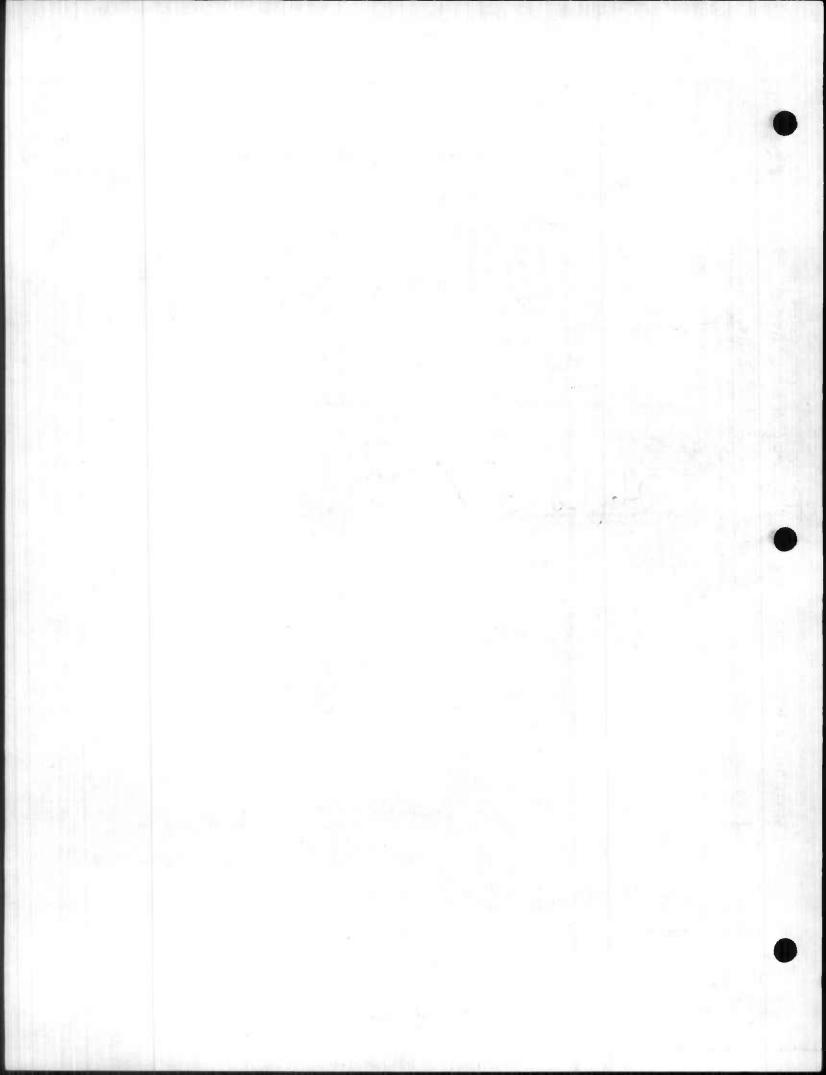


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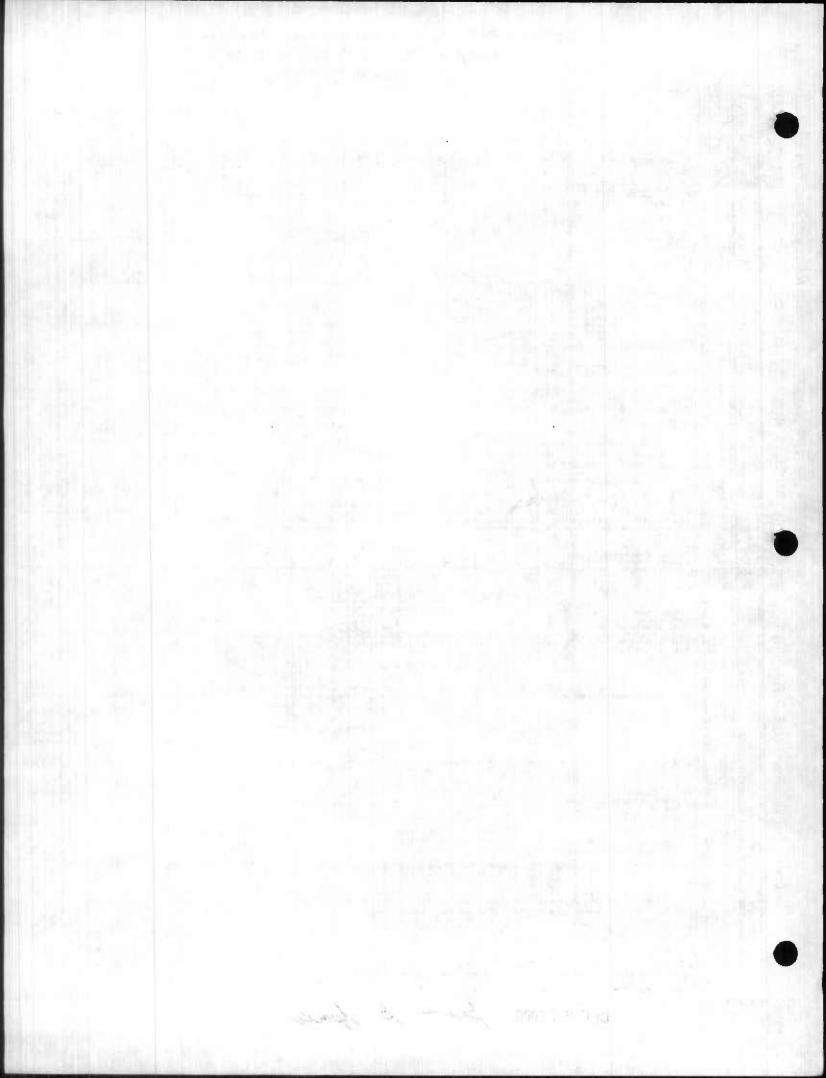
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Tima of Death 1. Decedant's Name (First, Middle, Last) Month Year **Physician** 1:25 2604 08/16 OCCH /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 40 aute 16 ward ,aure eslac If Undar 1 Yeer If Under 24 Hrs. 5. Social Security Number ge (in yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Min Months Days Hours DOM 2 F 61 Yrs. 244-58-3932 Director 6-14-1939 LaGrange, NC Usual Rasidence of Decedant the Manyland 10d. Insida City Limits 10a Stata 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or itema 23a or 28a-f shot traumatic svent, the Medical Examinal must be notified as 1 Yas 2 □ No Directo Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20708 U.S.A. 8820 Hunting Lane #202 permit. Pages 1 and 2 should be filed within 72 hours after death valepartment of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or hema 23a and injury or other traumatic event, the Heales Funeral 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ☒ No If Yes, Giva Yaar or Datas: 14. Race - Amarican Indian, Bleck, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Merifal Status 1 Nevar Married 2 Married **Black** 1 Yas 2₺ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Collega (1-4or 5+) 1 1/2 yrs Elemantery/Secondery (0-12) Government Machine Operator 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Surname) Iona Whitley James L. Pridgen 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8820 Hunting Lane #202 Laurel, MD 20708 Florence Pridgen/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Sfele 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 1-2-2001 Laurel, MD Maryland National 4 Donation 5 Other (Specify) 22. Nama end Addrass of Facility 21. Signature of Funerel Sarvice Licenses J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785 23a. Part1. Enfer the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure: List only one cause on each line. Approximata Interval Between Onset end Death **Physician** Immediata Ceusa (Final disaasa or condition resulting in death) /Medical Examiner Physician/Medical Examiner ed by the attanding physician and detached for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadieta causa. Enter Undarlying Ceuse (Diseesa or injury that initiated evants that initieted evants rasulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? signed by to 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of cause of death? been sig 24a. Was an autopsy performed? Completed r this certificate has I 1 Yas 2 No 1 Yes 20 No or Attending Physician: Be 25. Was casa rafarrad to medical 26. Placa of Daath (Check only one) Hospitel: Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 2 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA After this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: 28b. Tima of 5 Pending invastigation 1 Natural death. 1 ☐ Yas 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be detarmined 28a. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) after 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled 18 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and placa, and dua to the ceusa(s) and menner es stated.
2 Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, deeth occurred at the time, dete and place, and dua to the causa(s) and mannar stated. edical 29a, Certifian (Check only one)

Division of Vital Records, P.O. Box 68760.

State Registrar

31. Data filed (Month, Day, Year) DEC 2 9 2000

29b. Signature)and tiple of

Royce Fagan MD

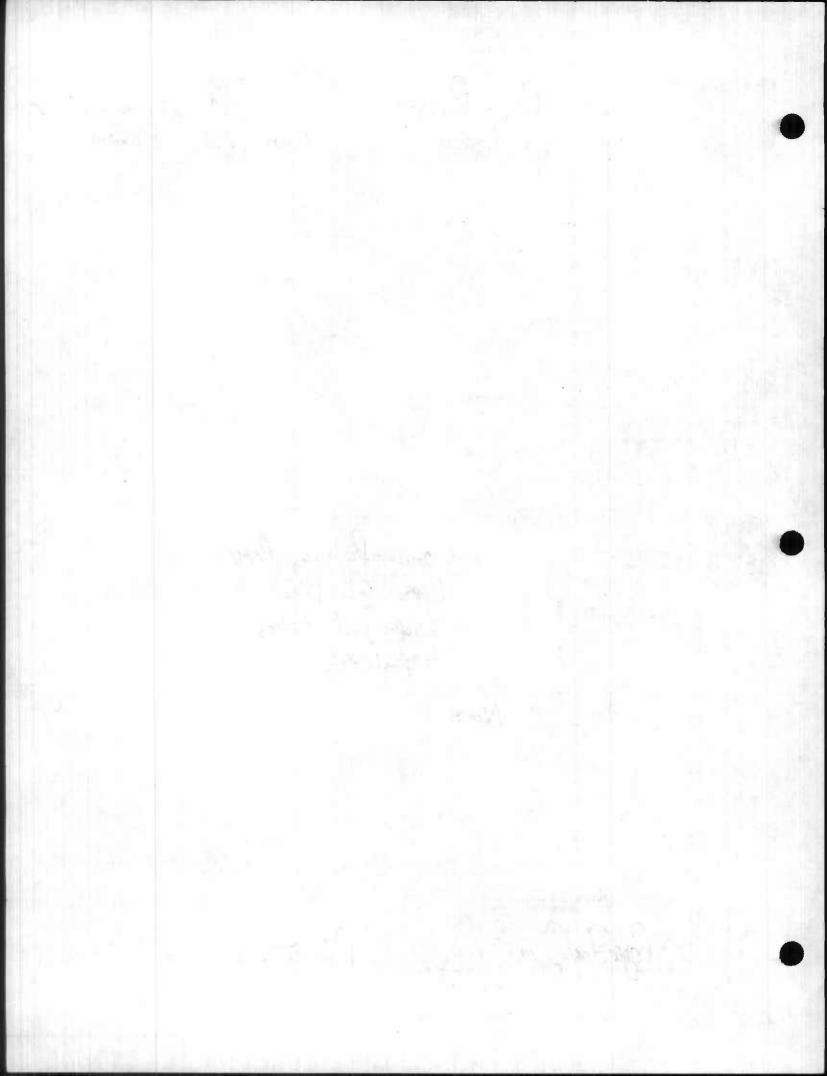
1221 Mercantile Lane Largo, Maryland 20774 32. Registrer's Signeture

30. Name and andress of person who complated causa of death (Itam 23a) (Type, Print)

290 Dicense number

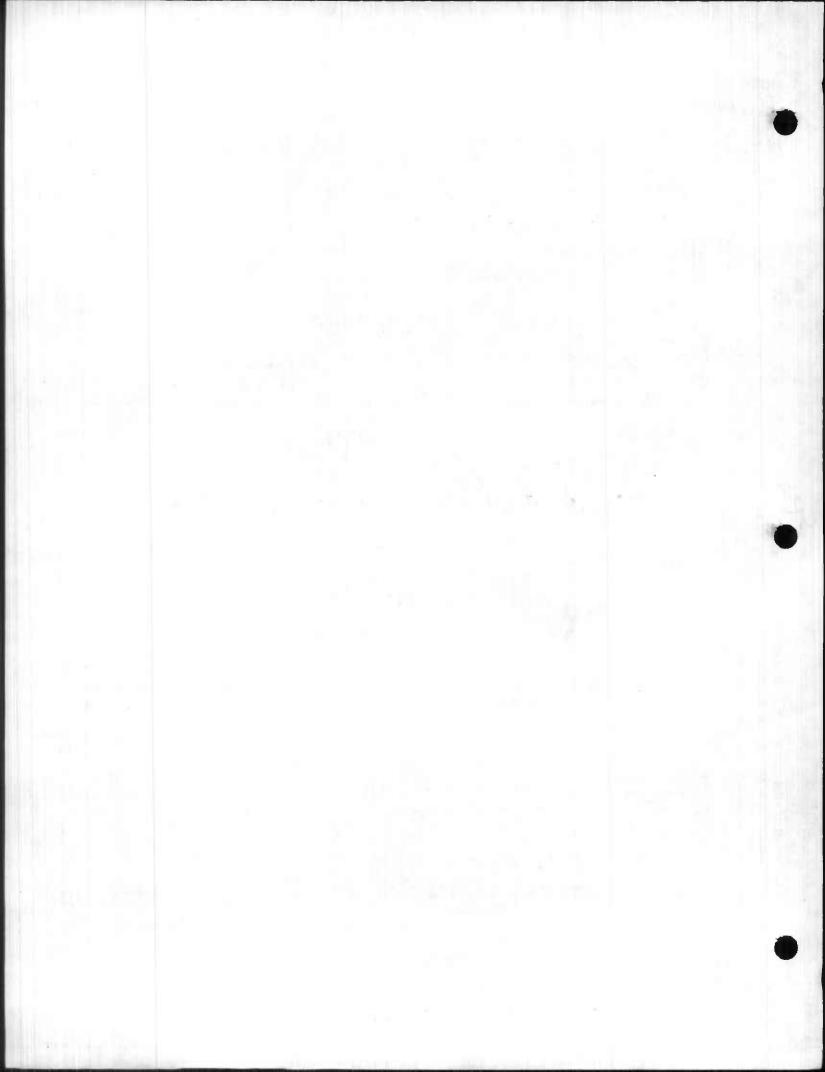
29d. Date signed (Mpnth, Day, Year)

4000



State of Maryland / Department of Health and Mental Hygiene

			State or Mary		ertificate of			g. No.	1,2007
	Physician	Decedent'a Name (First, Middle, Las					2. Date of Death Month	Day 1	(ear S. Time of Death
3	/Medical	Vernon R. Pose  4a Facility Name (If not institution, give	/			4b. City, Town, or L	December of Doubt	4c, County of	00 9; 30 AM
	Examiner		Ave nue			Riverd	ocation of Death	Prins ce	A /
4	Funeral	5. Social Security Number 6. Se	7. Age (In y	rs. last birthday	If Under 1 Year		8. Date of Birth		9. Birthplace (State or Foreign Country)
8	Director	227 34-0033	XM 2□ F 6	9 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 28,	1931	Virginia
	pue &	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or I	ocation				10d. Inside City Limits
	the Marylan 28a-f show northed at	Maryland Prince	George's	River	dale				1 ⊠ Yes 2 □ No
	vith the Ma	10e. Street and Number	0		10f. Zip Code		10	g. Citizen of Wh	at Country?
	deeth with the Maryland me 23e or 28e-f show creatible normed at neral Director	5900 62nd Avenue	- 1-1		2073	7		U.S.A.	
21215-0020	urs after Function by Fun	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 M Yes 2 □ No If Yes, Give Year or Detes: KOR		. Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2 ☑ No		pecify Yes or No- p Rican, etc.)		American Indian, White, etc.
5-0	72 ho	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of work	king	6b. Kind of Busi	ness/Industry
121	led within 72 ho ygiena. Wer than "naturn nt, fre Meolcal. Completed	Elementery/Secondary (0-12)	College (1-4or 5+)			3)		C-16 E	11
	tal Hygiena. d other than event, p. H. Be Comp	17. Father's Name (First, Middle, Last)		) ve	nding	18. Mother's Nam	e (First, Middle, N		mployed
Maryland	0 = 0 m	Joseph C. Po	sey			Sadie A	Audrey B	eavers	
lan	d 2 should the end Mer 7 is marke treumatic	19a. Informant's Name/Relationship (7		19b. Mai	ling Address (Street	and Number or Rui	ral Route Number,	City or Town, S	tate, Zip Code)
	them 27 in other tr	Brenda Vitale - D				Reserve F			oro, MD 20772
Baitimore,	8 - = 5	20a. Method of Disposition 1	Removal from State	cemetery, cri	position (Name of ematory or other place				ity or Town, State
H	Departmen Departmen Important: any injury :	4 Donation 5 Other (Specify			ans Cemet		12/29/00	Chelten	ham, Maryland
Ba	Departm. Popartm. Importar eny injur	Proces	Frank	G	22. Name and Addre asch's Fu 739 Balti	neral Hom	ne, P.A. nue, Hyat	tsville	, MD 20781
1		23a. Part1/Enter the bisease, or comp shock, or heart talkine. List only of	lications that caused the done cause on each line.	eath. Do not e	nter the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Finel	nH.	. 0	-		. 0	2.	
	Examiner	disease or condition resulting in death)			Tic Ca	rdi DVAS	curan s	115 can	2
L	ë		Due to	o (or as e conse	equence or):				
	axecuted in and itel-transit	Sequentially list conditions,	b. Due to	o (or as a conse	equence of):				
60,		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	С						
68760,	phys s tha	that initiated events resulting in death) Last	Due to	(or as a conse	quence of):				
Box (	2 2 4	E A HEALTH	d						
B	death cert e attendin d for use sician/N	Part II. Other significant conditions co	ntributing to death but not	resulting In the	underlying cause giv	en in Part I	23h. Did to	bacco use cont	ribute to the cause of death?
P.0	that the death cert ed by the attending detached for use of Physician/M								Probably 4 Unknown
	w requires that been signed b should be data should by Ph								
Records,	The law requires the state has been signed, page 2 should be d						24a. Wes ar perform		24b. Were autopsy findings available prior to completion of cause
Rec	has b			13					completion of cause of death?
Vitai	scentificate has b director, page 2 s	25. Was case referred to medical				00 01	1 Ye		1 Yes 2 No
>	Physician: this cartific ral director, TO Be	axaminer?	Hospital:	□ ER/Outpatio	ent 3 DOA Oth	oc:	th (Check only one		(Specify)
ion of	After fune	27. Mannar of Death  1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year		of 28c. Injur		28d. Describe ho		1-1-1
Division	is after death. It after death. It bliesctor: After the din by the funera deatline.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, s	treet, factory, office		28f. Location (Str City or Town	reet and Number , State)	or Rural Route Number,
	Hospit 24 hour Funer staly fill	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my liner: On the basis of exam and manner stated.	nowledge, dea inetion and/or i	th occurred at the tin nvestigation, in my o	ne, date end place, pinion, death occur	end due to the ca red at the time, da	use(s) and mani ite and place, an	ner as stated. Indicate to the cause(s)
	within 2 the comple	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed	(Month, Day, Year)
		Salvador Su	lester Do		HOO.	53727	D	ecembe	127, 2000
	10/11/01	01101	ompleted cause of death (t	tem 23a) (Type	Print)	Char	1 100	10.0	2-72-
	State	31. Dete filed (Month, Day, Year)	te, 300 A	mature .	1 Drive	, vere	17 147	Linna	20/17
	Registrar	DEC 2 8 2000	Serva	G.	land,				



K	DBIINSON Physici /Medio	an	amend item 23a,b,2 1. Decedent's Name (First, Midd BETTY L. RO	le, Last)		1,12,0	1 y1 06	anoa	00	Joann		2. Data of Deat Month DECEMBE	Day	Year	3. Time of Death 2:45P.M.
	Examir		4a Facility Name (If not institution			nber)						ocation of Death	4c. Count	y of Death	
			2860 SCHOOLHOUS	-				1 40 11 1		WHEAT				OMERY	
	Funeral Director		5. Social Security Number 577–62–8828	6. Sex 1 ☐ M	2 <b>X</b>	7. Age (In yrs <b>57</b>	. last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day, Apr. 10,	1943	9. Birthplac Country Wash	pa (State or Foreign
	p .		Usual Residence of Decedent  10a. State 10b. County			10a C	ity, Town or Lo	nation						104	Lastela Olb. I Imite
	or 25a-f show be notified at	Director	Maryland Montgo				aton	oMiton		incl			0.000		Inside City Limits Yes 2 No
	23a or 1		10e. Street and Number 2860 SchoolHou	se Ci					Zip Code 20902			"		What Country USA	77
980	urs after deat at', or flame 2 Examiner mu	by Funeral	11. Marital Status  **Navar Married 2   Mar 3   Widowed 4   Divorced	ried	Was Dece Armed For 1 Tyes If Yas, Giv Year or Da	2 No a		Was Dece If Yas, spe 1  Yes	No.	lispanic Ori an, Mexicar Specify:	gin? (Sp 1, Puarto	pecify Yes or No- p Rican, atc.)	Bla	ce - American ack, White, etc	2.
2-0	S-bo	pete	15. Deceder (Specify only highe					dent's Usu	al Occup	ation during mos	t of word	kina	16b. Kind of E	Business/Indu	stry
2121	i within jiene.	Completed	Elementary/Secondary (0-12) 12th		College (1 +04	-4or 5+)	life.	gram	ise retire	d)	i or won		U.S. G	overnme	ent
Maryland 21215-0036	uid be filed fental Hyg rised other tic event,	To Be C	17. Father's Nama (First, Middle, Louis W. Robi									e (First, Middle, M	Maiden Sume	m <i>e)</i>	
any	a ma		19e. Informent's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State										n, Stete, Zip C	ode)	
2	and and a		Florence Rob	inson	/ Mo	ther	er 415 Russell Ave Apt.211 Gaithersburg, Md. 20877							20877	
more	Pages 1 ant of He ht: If Item ry or oth		20a. Method of Disposition  1 X Burial 2 Cremation 4 Donation 5 Other (5		oval from S	State	Placa of Dispo cometery, cre edar Hi	matory or	other pla		1	Date /6/2001		- City or Town	
Balti	Departri Departri Importa eny inju		21. Signature of Funeral Service	Ligensee	4	us	F	razio	nd Addre	Funei	al	Home, Inc. Wash.			
	Physician /Medical		23a. Part1. Entar the disaasa, o shock, or heart failure. Lis					ter the mo	de of dyi	ng, such as	cardiac	or raspiratory arre	est,	i Ir	pproximate Itervel Between Inset and Death
	Examiner		disaasa or condition resulting in death)	a. C	ARDIAC	ARRHYTH									
L,	₽ #	ner			HYPERT		or as a conse THEROSCI			DIOVAS	CULAR	DISEASE		1	
.60	be assecuted siclen and burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	<b>S</b> b. –		Due to (	or as a conse	quenca of)	):			10.76			
687	ifficate ng phys es the	Physician/Medical	Ceuse (Disease or injury that initiated events resulting in death) Last	c		Dua to (	or as a consec	quance of)	:						
Box	etten for u	clan										T		1	
P.O.	hat the ded by the		Pert II. Other significant conditi	one contrib	ontributing to death but not resulting in the underlying cause given in Pert I.						23b. Did to	-	3 Probe	he cause of death bly 4 Unknow	
Records,	been s	Completed by		High							24a. Was a perform		avail	a autopsy findings able prior to pletion of causa ath?	
R	0 -	mo										10(Y	as 2 No	100	Yas 2 No
Vital		Bec	25. Was case referred to medica	ıl						26. Place	of Dea	th (Check only on	10)		
<b>&gt;</b>	2 00	To	examiner? 1 Types 2 No	Hosp	oital:	npatient 2	ER/Outpatie	nt 3 D	OA Ott	her: 4 Nu	ursing H	ome 5 Reside	ence 6 🔀 O	ther (Specify)	SCENE
ion of	Attending Physical Attention octor: After this by the funeral		27. Manner of Death  1 Netural 5 Pendi 2 Accident invest		28a. Dete d (Mont	of Injury h, Day Year)	28b. Time of Injury	M M	28c. Inju Wo 1 [	ryat rk? ∣Yes 2 🗆	No	28d. Describe ho	ow injury occu	urred	
Division	The direct	Certification:	3 ☐ Suicide 6 ☐ Could determined		28e. Placa buildir	of Injury - At h	nome, farm, st	reet, facto	ry, offica			28f. Location (St City or Town		nber or Rural I	Route Number,
	6 0 = 6	O							4 -4 41 - 41		d mla aa	and due to the o			
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifyi (Check only one) 2 Medical	Examiner:	on the ba and mann	sis of examin	owledge, deat ation and/or in	n occurred vestigation	n, in my	me, date an opinion, dea	th occu	rred at the time, d	ete end plece	nanner as stat , end due to ti	he ceuse(s)

State Registrar

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

TACK M. T.MS M.D. 111

31. Data filed (Month, Day, Year)

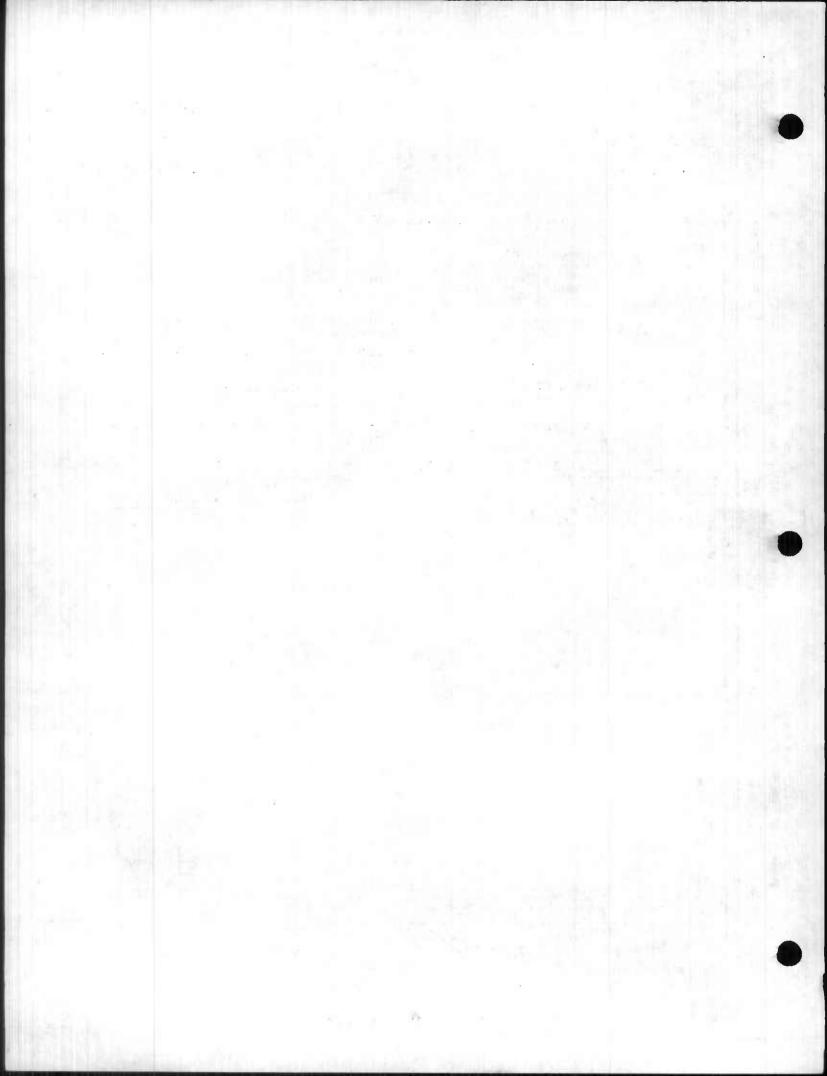
JAN 0 5 2001

32. Registrar's Signatura

111 Penn Street, Baltimore, Maryland 21201 ORIGINAL ORIGINAL

O.C.M.E.

DECEMBER 30,2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month ROBINSUN ELIZABET 11:20 PM 21, 2000 December 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Cross Hospita Silver Spring Montgomery If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1□ M 2☑ F Months 82 Yrs. 172-24-0756 Sept.11, 1918 Pennsylvania Usual Residence of Deceden 10a State 10b Counts 10c. City. Town or Location 10d. Inside City Limits 1 No 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20901 321 University Blvd West #216 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Yeer or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Black 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) J. C. Penny Retail Sales Person 17. Father's Name (First, Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Aldene Pinkard William Patterson 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2200 Parallel Lane, Silver Spring, MD 20904 J. Wallace Robinson - Son 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 Cremetion 3 Removal from State 12/27/00 Silver Spring, MD Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Marshall's Funeral Home, Inc. marsnall's Funeral Home, I 4217 9th Street N.W. Washi ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, rheart failure. Ust only one cause on each line. 4217 9th Street N.W. Washington DC 20011 Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) omINAL AURTICHNEURUP Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings evelleble prior to 24a. Wes en autopsy completion of cause of death? 1 ☐ Yes 2 No 1 □ Yes 2 □ No

**Physician** /Medical **Examiner** 

the buriel-transit

98 attending p use

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After t

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completaly filled in by the funeral process.

page 2 should Completed

director, Be

filled in by the funeral

pue

physician

The law requires that the death cartificete be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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2

Certification:

Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Wedical Examiner must be nothed at

Director

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Completed

with the Maryland

death

filed within 72 hours efter

Hygiena.

Pages 1 and 2 should be fill iment of Health and Mentel Hilant: If item 27 is marked out

other

8

permit. Page Department of important: If any injury or once.

other

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest

Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural

3 ☐ Suicide

2 Accident

4 Homicide

12 Nnpatient 2 ER/Outpetient 3 DOA 5 Pending investigation

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

26. Place of Death (Check only one)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 29e. Certifier

6 Could not be

Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated.

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29b. Signeture and tills of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

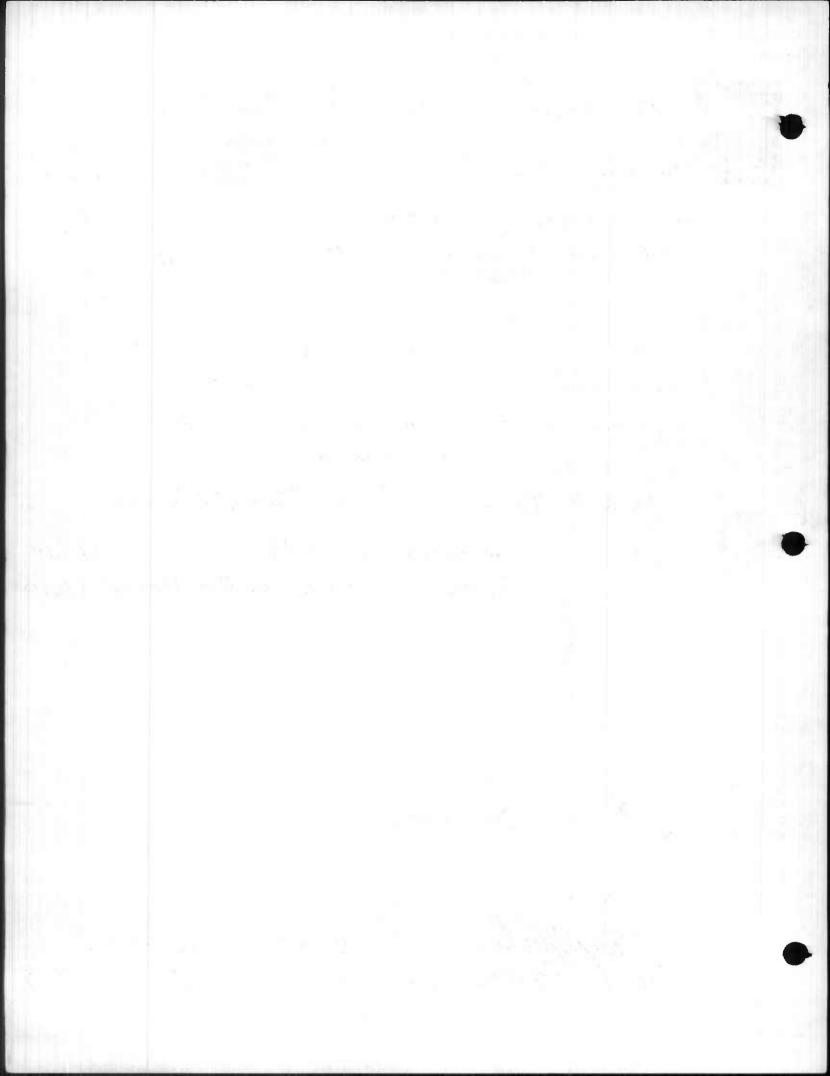
who completed cause of deeth (Item 23e) (Type, Print)

11120 New Hampshre Are \$01 D. RUBGN MO GARR 31. Date filed (Month, Day, Year)

State Registrar

DEC 2 6 2000

Registrar's Signeture



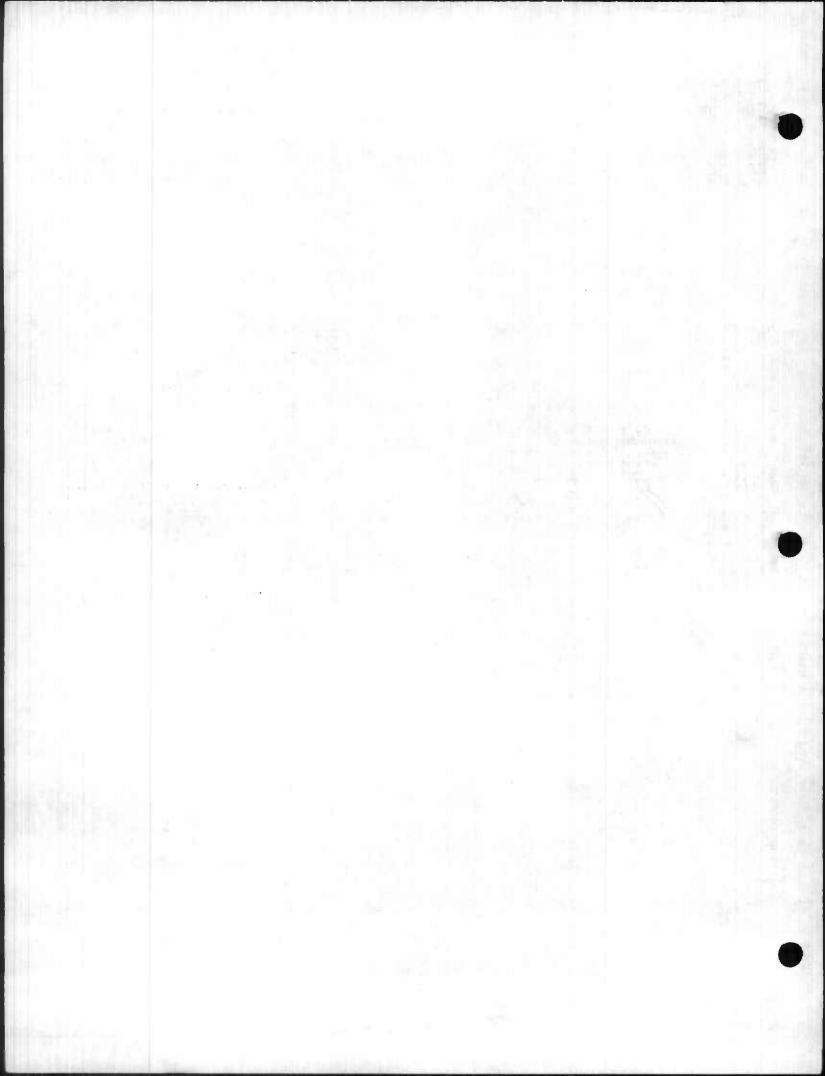
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** BARBARA JEAN ROBINSON December 21, 2000 14:06 /Medical 4e Facility Nema (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince Georges' 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. Dete of Birth (Month, Day, Year) 02-07-37 5. Sociel Security Number 6. Sax Birthplece (State or Foreign Country) **Funeral** Min Deys 1□M 21 F Months Hours 235-56-8736 63 West Virginia Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside Clty Limits 1 Yes 2 No Maryland Prince Georges Directo Fort Washington 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10013 Moreland Street 20744 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give \*\* Yaar or Datas: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indian. 11. Marital Stetus Black, Whita, etc. 1 Never Married 2 Merried 1 Yes 2√ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black. 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Weigh & Wrapper, Meat Dept. Safeway Foods 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill Health and Mental H tem 27 is marked oth Hamp Early Margaret Richardson 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 Robert Robinson / Husband 10013 Moreland Street, Ft. Wash., MD 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State Dete Pages 1 Burial 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) Harmony Memorial Cemetery 12-29-00 Landover, MD 22. Nama and Addrass of Facility Strickland Funeral Services, PA 21. Signature of Funeral Service Licensee 6500 Allentown Road, Camp Springs, MD Part. Entar tha disease, or complications that caused tha death. Do not anter tha mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediete Causa (Final diseesa or condition rasulting in deeth) /Medical mms Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/M Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? bilitation, Congestiva Heart Failure 12 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings available prior to completion of cause of daeth? Stage Renal Disease, Chronic Ob structive 24e. Wes en autopsy Insulin Dependent Diabetes Sof menory Disease, 1 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 28a. Dete of Injury (Month, Day Year) 27. Manper of Deeth 28c. Injury at Work? 28d. Dascribe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledga, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and plece, and due to the cause(s) and menner stated. (Check only Within 2 To the 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12825 Old Fort Rd Fortwash, MD 20744 mo 32/ Registrar's Signature

DHMH 16 Rev 6/95

Registrar

· Aparks



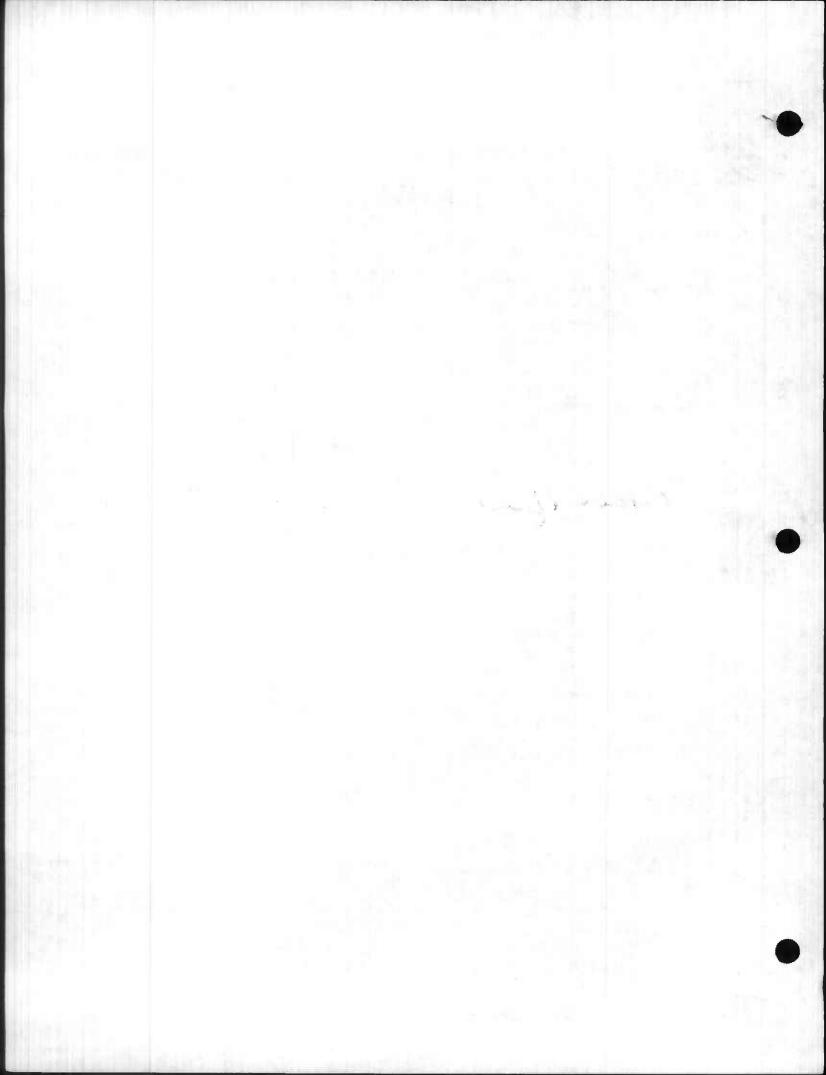
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Charles H. Reintzel, Jr. 12:00 P.M. December 23, 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent Center Crofton Anne Arundel 5 Social Security Number If Under 1 Year | If Undar 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** XXM 2DF Months Days Hours Yrs 719 16 3073 88 Director Oct. 24,1912 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shot traumstic event, the Medical Examinar must be notified as 1 Yas 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 72 hours after death with 1515 LaVale Terrace 21804 United States Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas ② TNo If Yas, Give Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Orlgin? (Specify Yas or No-ff Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 Nevar Married 2 Married 1 ☐ Yas % No Specify. Specify: White þ 3€Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Government Elamantary/Secondary (0-12) College (1-4or 5+) Air Force 12 Civilian Researcher 18. Mothar's Nama (First, Middla, Maidan Surname) 17. Fathar's Nama (First, Middla, Last) and Mentel permit. Peges 1 and 2 should be Department of Heelth and Mente Important: If Nem 27 is marked any Injury or other treumatic ev page. Charles H. Reintzel, Sr. Agnes Swigert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Kathryn E. Binger Daughter 3707 Nile Road Davidsonville Maryland 21035 20b. Place of Disposition (Name of cematery, cramatory or other place) December 26, 200. Location - City or Town, State 20a. Mathod of Disposition Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) Fort Lincoln Cemetery Brentwood Maryland 21. Signatura of Funaral Sarvice License 22. Name end Addrass of Facility Robert E. Evans Funeral Home, Inc. Muchael 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one-cause on each line. Approximata Intarval Batween Onsat and Daath **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Mys condid Infaction Lours Examiner Physician/Medical Examiner that the death certificate be executed Sequentially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Diseasa or Injury that initiated avants resulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown artery dis een by The law requires 24a. Was an autopsy performed? 24b. Wara eutopsy findings available prior to Mulli hos completion of causa of daath? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Physician: 25. Was casa rafarrad to madical examiner? Be 26. Placa of Daath (Check only ona) To Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No epital or Attending Physical Process after death.
Incred Director; After this y filled in by the funerel di this 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 5 Pending invastigation 1 Natural 1 Yas 2 No 2 Accident 6 Could not be 281. Location (Street and Number or Rurel Route Number, City or Town, Steta) 3 Suicida 28a. Place of Injury - At home, ferm, street, fectory, offica building, atc. (Specify) 4 T Homicide within 24 hours 1 Certifying Physician: To the best of my knowledga, daeth occurred at the time, date and plece, end due to the cause(s) and manner as stated
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, deta end place, end due to the ceuse(s) and manner stated. edical 29a. Certifier completely (Check only one) 29c. Licanse number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian pollino D-40521 December 23,2000 30. Nama and addrass of person the complated cause of death (Itam 23a) (Type, Print) 7845 Oak wood Road Punte DR MAHESH OCHANEY gren Burnieg MD

State Registrar 31. Data filed (Month, Day, Year) DEC 2 7 2000

32 Registrar's Signatura

Sparks



Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month Year **Physician** 21,2000 10:30 P.M. James C. Richardson December /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Lorien Nursing Center ff Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) May 7, 1910 9. Birthplace (State or Foreign Country) Virginia **Funeral** Days XX M 2□ F Months Hours Min 578-10-1653 90 May Director Usual Residence of Decedant 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28a-f above traumetic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6334 Cedar Lane 21044 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Stetus Bleck, White, etc. hours after Never Merried 2 Merried 1 Tyes 2 Now II If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0036 1 Yes 2√√No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within College (1-4or 5+) Elementery/Secondery (0-12) Construction 10 Tile Setter 190 permit. Pages 1 and 2 should be ille Department of Health and Mental Hy Important: If them 27 is marked othe any injury or other traumatic avent, 000s. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Caddy Nelson Willie Richardson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9276 Cherry Lane Laurel, MD 20708 Alcena Wilson / Sister 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition XX Buriel 2 Cremetion 3 Removel from State Ft. Lincoln Cemetery December 27,2000 Brentwood, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Ft. Lincoln Funeral Home 21. Signature of Funeral Service Licensee elacer 3401 Bladensburg Rd. Brentwood, MD 20722 23a Part L Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. Let only one cause on each line. Approximate Intervel Betwe Onset end Death **Physician** Immediete Cause (Finel disease or condition resulting in death) /Medical 1 week Acute Renal Failure Examiner Due to (or es e consequence of): Examiner Recurrent Aspiration pneumonia acute attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, years Parkinson's features Physician/Medical Due to (or es e consequence of): USB BS t years Chronic Schizophrenia Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by to 1 Yes 2 No 3 Probably W Unknown by 24b. Were eutopsy findings eveilable prior to completion of cause of death? should t 24e. Wes an eutopsy performed? Completed page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Physician: 25. Wes case referred to medical examiner? Be 28. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) L<sub>o</sub> 1 Yes 2\OXNo this After this funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury To the Hospital or Attending Physicial 24 hours after death.

To the Funeral Director: After the completely filled in by the funera 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1XXVeturel 5 Pending investigation eral Director: A 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 T Homicide Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number December 22,2000 D31575

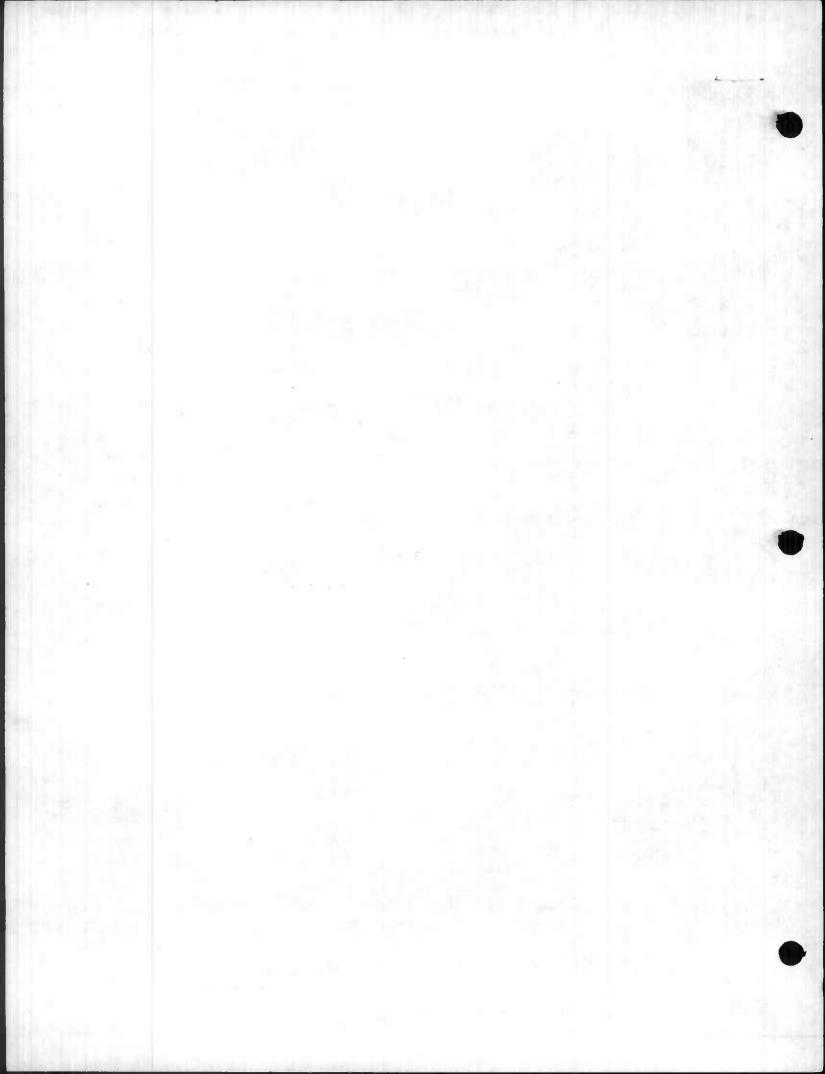
State Registrar

31. Dete filed (Month, Day, Year) DEC 2 8 2000

Richard Kolodrubetz, M.D. 9501 Old Annapolis Rd. #200 Ellicott City, MD 21042 2. Registrer's Signaturg

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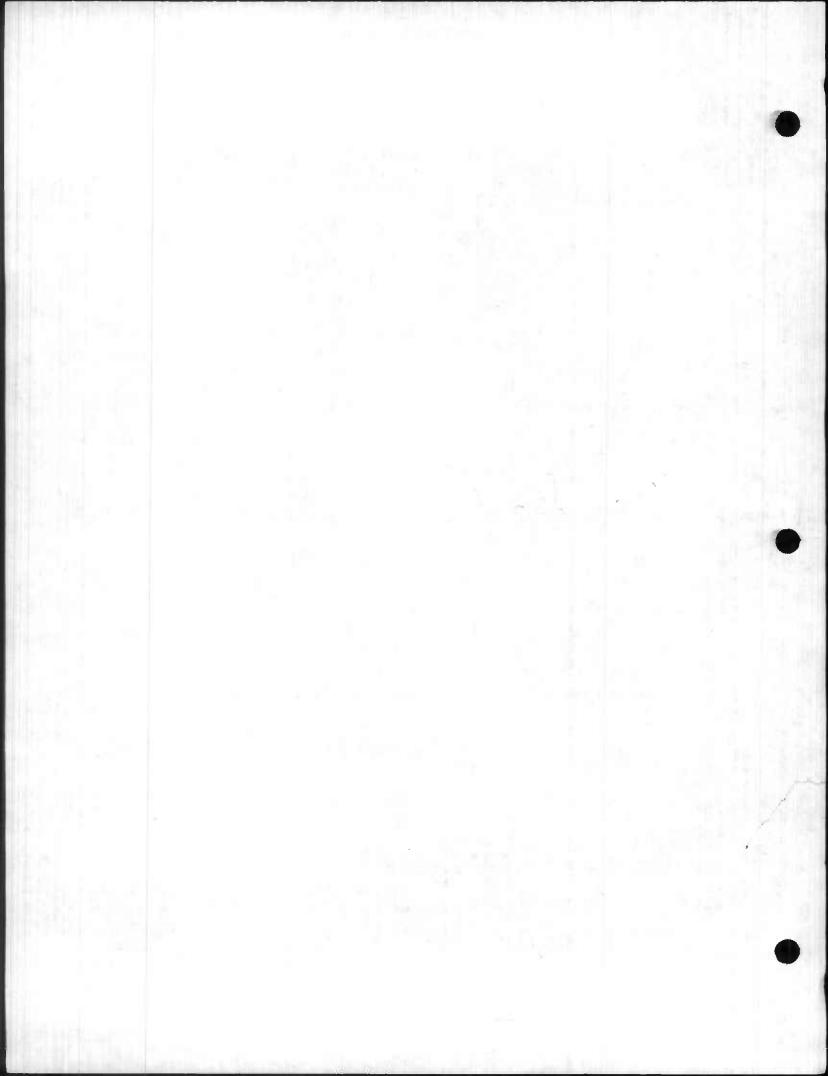
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State of Ivialyia		cate of I		, ,	g. No.	42993
	4	1. Decedent's Name (First, Middle, Last)					2. Dete of Deat Month		3. Time of Deeth
	Physician /Medical	Helen Magee Ross	siter				December		
- }	Examiner	4a Facility Name (# not institution, give si	treet end number)		4	b. City, Town, or L	ocation of Death	4c. County of i	
		Washington Adventi	st Hospital			Takoma F	ark	Montgo	mery
	Funeral	5. Social Security Number 6. Sex	7. Age (in yrs.		Inder 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Dey,		Birthplace (State or Foreign Country)
	Director	577-09-0699	M 2XF 89	Yrs.	nths Days	Hours Min.	Dec. 16	, 1911	Washington, DC
	aryland ahow dall	10a. Stete 10b. County	10c. Ci	ty, Town or Location	1				10d. Inside City Limits 1 X Yes 2 □ No
	with the Mary a or 28a-1 ah be notified.	Maryland Prince Ge	orge's U	niversity					
	Dir Den	10e. Street and Number		100	f. Zip Code		10	0g. Citizen of Wha	
	ath w	6511 Adelphi Road				0782	4 4	U.S.A	
020	us after doath viti, or theme 23s Comfiner must by Funeral	11. Merital Status  1 Never Merried 2 Merried  3 🖾 Widowed 4 Divorced	2. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		specify Cubs	lispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	Black, 1	American Indian, White, etc. White
0		15. Decedent's Educ	ation	16a. Decedent's	Usual Occup	ation		16b. Kind of Busin	ess/Industry
Maryland 21215-0020	ed within 72 ho trigione. Ser than "nature it, the Medical.	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	OT use retired	during most of wor			
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and	Be week								
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altimore	ages of of or	1 ☑Burial 2 ☐ Cremetion 3 ☐ Re	MINOVALITURE STATE						
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	and the same	23a. Pert1. Enter the disease, or complic shock, or heart failure. List only one	ation that caused the deal	th. Do not enter the	mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Intervel Between Onset and Death
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	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a.	Kesky	nations	tan	luce			3 Week
		resulting in Gealin)	Due to (	or as a consequence	e of):				3 Weeks
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68760,		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.							
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Records,	signed I be det				1		24e. Wes e	n autonou i	24b. Were eutopsy findings
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of Vital	Physician: The this certificate ral director, page TO Be Co	25. Wes case referred to medical examiner?	- Indiana		Oth		th (Check only on	e)	
£	Pis Pis	1 Yes 2 No			DOA Oth	4   Nursing H	ome 5 Reside		(Specify)
2	Aling P. Atter t funant funant	27. Menner of Death  1 Meturat 5 Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe ho	ow injury occurred	
Sio	Attending r death.  octor: After funs by the funs if ication	2 Accident investigation 3 Suicide 6 Could not be		М		Yes 2 □ No			
Division	tal or Attending P rs after death. al Director: After t led in by the funare Certification:	4 Homicide determined	28e. Pleca of Injury - At h building, etc. (Speci	ome, farm, street, fa fy)	actory, office		281. Location (St City or Town		or Rurel Route Number,
	rai Delli O								
	To the Hospital or Attending Within 24 hours after death. To the Funeral Director: Attentionable and the funeral preceder Attention of the funeral preceder and the funeral Medical Certification		clan: To the best of my known: On the basis of examine and manner steted.						
	within 2 To the comple	29b. Signeture and title of certifier	1 1/1	A COMPANY	29c. Licens	e number	2	9d. Date signed (i	Month, Dey, Year)
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	(in)	30 Name and address of names who are	nalated cause of death (tto	m 23a) (Time Drine)	37 10				
	(12)	30. Name and address of person who con MoBARH C	npleted cause of death (Item R ) M, 76 10	CARROLL	AVE,	TAKOM	A PAR	K, M.	D 20912
	State Registrar	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature 4	south !	,			



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ď	219-74-8782	Sex 1□ M 2⊠ F	91 Yrs. last birthday)	Months Days	Hours Min.	8. Date of Birt (Month, Da June 1	y, Year) 6, 1909	9. Birthplace (State or For Country) Pennsylvani			
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Lir			
or	Maryland Ceci	11	Elkton					1 <b>X</b> Yes 2□			
Director	10e. Street and Number			10f. Zip Coda			10g. Citizen of Wh	nat Counfry?			
	526 Hollingswor	th Avenue		2192	1		United	States			
by Funeral	11. Marital Stetus  1 □ Never Maπied 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 No If Yes, Give Yaar or Dates:	lo	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Maxican, Puerto Specify:	pecify Yes or No Rican, etc.)		- American Indian, White, etc. White			
	15. Decedent's E (Specify only highest gi					on 16b. Kir		nd of Businass/Industry			
mpi	Elementary/Secondary (0-12)	Collega (1-4or 5	+)	DO NOT use retired nemaker	d)		In her own ho				
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Be C	Gustav Burkle	17			Cathe						
10	19a. Informant's Name/Relationship	er, City or Town, S	State. Zip Code)								
	Louise McFate/0				rive, Ear						
	20a. Method of Disposition	DOUBLII .	20b. Place of Dispo	osition (Name of		Date		City or Town, State			
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		1	matory or other pla		10 (00 (	0 01				
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility										
	Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, Maryland 21921										
	23a. Part1. Enter the disease, or cor	mplications that caused						Approximata			
	shock, or heert failure. List only	y one ceuse on each lir	18.					Onsat and Deat			
Н	tmmediata Cause (Final	120	2 200 6	Las	0	1		3			
	disease or condition rasulting in death)  Bua (or as a consequence of):										
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ysic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.										
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Be Completed by Physician/Me	2191	1		,	ot 108	24a. Was	an autopsy	24b. Wara autopsy findi			
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ошо						10	Yes 200 No	1 ☐ Yes 2 ☐ No			
Ö	25. Was cese referred to medical	T			26 Place of Dec			7 10 165 20 160			
0	examiner?	26. Place of Death (Check only one)  Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Aurursing Home 5   Residence 8   Other (Specify)									
-	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred									
Ë	1 DNatural 5 Pending		Year) Injury		Yes 2□No						
dion.	2 ☐ Accident investigation		ury - At home, farm, st	28f. Location ( City or Tor	Street and Number wn, State)	r or Rural Route Number,					
	2 Accident investigate 3 Suicide 6 Could not 4 Homicide detarmine	building, ato									
a cermication:	3 Suicide 6 Could not detarmine	building, at	of my knowledge, deat	h occurred at the ti	me, date and place	and due to tha	ceusa(s) and man	nnar as stated.			
edical Certification:	3   Suicide 6   Could not detarmine 4   Homicide   Certifier 1   Certifying P	building, at	examination and/or in								
medical celtification:	3 Suicide 6 Could not detarmine  29a. Certifier 1 Certifying P (Check only 2 Medical Exa	Physician: To the best of iminer: On the basis of	examination and/or in		opinion, death occu		date and placa, ar				
medical Certification:	3   Suicide 4   Homicide  29a. Certifier (Check only one)  Check only one)  6   Could not detarmine  6   Could not detarmine	Physician: To the best of iminer: On the basis of	examination and/or in	ivestigation, in my	opinion, death occu		date and placa, ar	nd due to the cause(s)			
Medical Certification:	3   Suicide 4   Homicide  29a. Certifier (Check only one)  Check only one)  6   Could not detarmine  6   Could not detarmine	Physician: To the best of and manner sta	examination and/or inted.	29c. Licens	opinion, death occu		date and placa, ar	nd due to the cause(s)			
Medical Certification:	3   Suicide 4   Homicide  29a. Certifier (Check enly one)  29b. Signature and fitle of certifier	Physician: To the best of and manner sta	examination and/or inted.	29c. Licens	opinion, death occu		date and placa, ar	nd due to the cause(s)			





#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

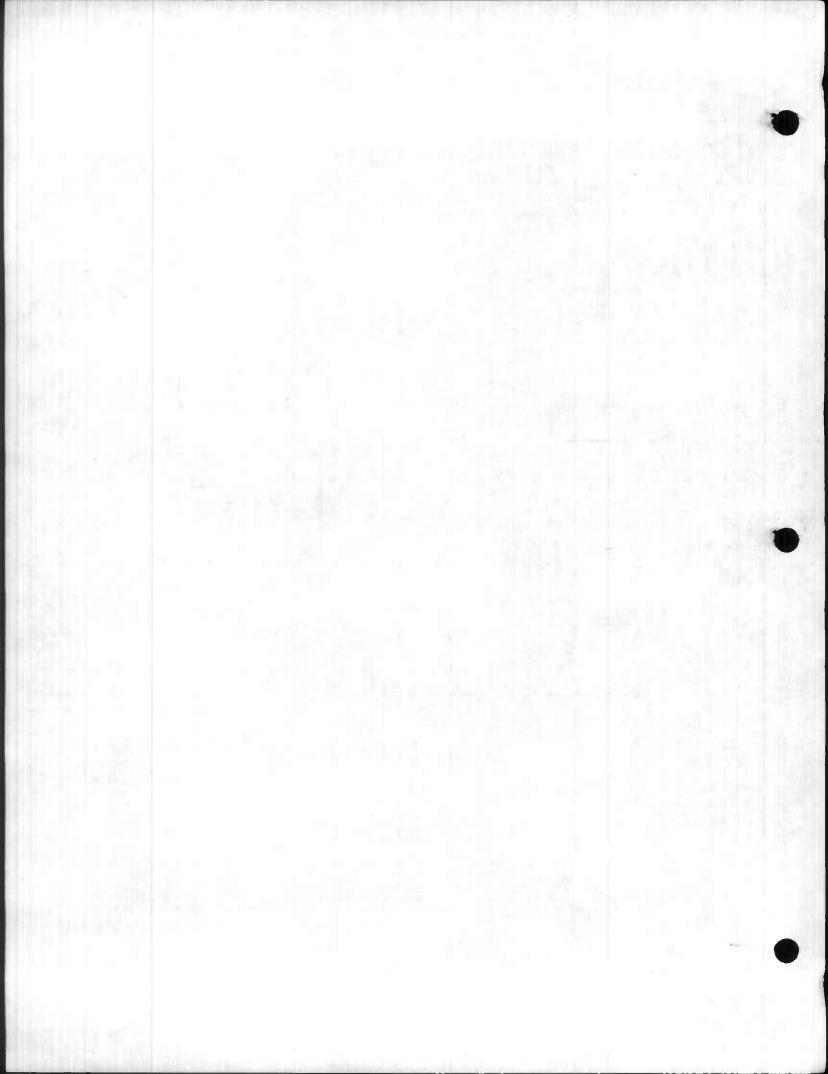
State of Maryland / Department of Health and Mental Hygiene 0 0 1, 2995

			(	Certificat	e of	Death		Reg. No.	** (		
Physician	1. Decedent'a Name (First, Middle, La Henry Sizemore					D	2. Date of Dea	ath	000	3. Time of Death 1:00A.M	
/Medical Examiner	4a Facility Neme (If not institution, give					4b. City, Town, or		· ·			
LXammer	305 Piney Cree	k Lane				North E		Ceci	.1		
Funeral Director	5. Social Security Number 6. S 236-46-3755	Sex 7. Age (In yr.		Months	Deys	If Under 24 Hrs Hours Min.	8. Dale of Birt (Month, Da pril 1	y, Year) 5,1934	Countr	ce (State or Foreign) Virginia	
2	Usual Residence of Decedent		No. 7.								
Menylar H show fied at tor	Maryland Cecil		1	or Location 1 East					10	d. Inside City Limits 1 ☐ Yes 2 ∑ No	
Se or 28a-f sh at be notified.	10e. Streel and Number 305 Piney Cree	k Lane		10f. Zij	Code 190	1		10g. Citizen of V		y?	
d 2 should be filed within 72 hours after death and Mental Hygens. T is marked other than "natural", or terms 23 traumetic event, the Medical Examiner must To Be Completed by Funeral	11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 25140 If Yes, Give Yeer or Detes:	1 ☐ Yes 2√1√No If Yes, Give			edent of Hispenic Origin? (Specify Yes or Noecify Cuben, Mexican, Puerto Rican, etc.)			No- 14. Race - American Indian, Bleck, White, etc.  Specify: White		
72 ho Real Real	15. Decedent's E		16e. C	Decedent's Usuel Occupation		deina	16b. Kind of Bu	siness/Indu	ustry		
ad within 72 ho ygens. ser than "natur it, the Medical. Completed	(Specify only highest grades) Elementery/Secondary (0-12)	College (1-4or 5+)	Wire Cutt			e during most of working red)		Elkton Sp		rkler C	
	17. Father's Neme (First, Middle, Last	)				18. Molher's Na	ne (First, Middle, Maiden Surname)				
ind be in the series of the se	Emit Sizemore				Zella White						
and and and and and and and and and and	19e. Informent's Neme/Reletionship (	Type, Print)	19b.	Mailing Addres	s (Street	and Number or Ri	ural Route Numbe	er, City or Town,	State, Zip (	Code)	
od 2	Ella Grace Siz	emore-wife	305	Pine	y C	reek La	ne Nort	h East	, Md.	21901	
ermit. Pages t a bepartment of He reportant: if then iny injury or other stice.	Ella Grace Sizemore-wife 305 Piney Creek Lane North East, Md. 219  20e. Method of Disposition  20b. Plece of Disposition (Name of cemetery, crematory or other place) 4 Donetion 5 Other (Specity)  20b. Plece of Disposition (Name of cemetery, crematory or other place) Elkton Cemetery  12/26/00 Elkton, Md.										
permit. Departm imports any inju	21. Signature of Female Service Light	ineo H				ss of Fecility G	ee Fund			21	
	23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plidations that caused the de	alh. Do no							Approximate Intervel Between	
fireste be axecuted g physician end as the buriel-trensit edical Examiner	disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last	bDue to	(or es e co	onsequence of)		cstili					
thending or use lan/M										the cause of death	
es that the designed by the a be deteched for by Physic	Portin. Other significant conditions of	orthodring to death but not re	ssutting in	ine underlying	vause yn	ren in Faiti.				ably 4 Unknow	
requir						4.35	24a. Wes	an eutopsy med?	CON	re autopsy findings ilable prior to apletion of cause eeth?	
The la	The state of the s						10	Yes 2 No	10	Yes 2 No	
sician: The law certificate has to director, page 2 s	25. Wes case referred to medical			1000		26. Place of De	eth (Check only o	one)	1		
Physicien: Tr this certificate ral director, pa	examiner?	Hospitel: 1 Inpatient 2	□ ER/Out	patient 3 D	OA Oti	an.			er (Specify	)	
Ing Phy After thi funeral	27. Menner of Death  1 Neturel 5 Pending investigation	28a. Dete of Injury (Month, Dey Year)		me 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred							
	3 Suicide 6 Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, fer	m, street, factor	ry, office		28f. Location ( City or To	Street and Numb vn, Stete)	er or Rural	Route Number,	
Ne Hospital or nn 24 hours afti Ne Funeral Dir pletely filled in edical Ceri		nysician: To the best of my kr niner: On the basis of examin end manner steled.									
within 2 To the comple	29b. Signature end title of certifier	1		29	c. Licens	se number		29d. Date signe	d (Month, E	Day, Year)	
->-0	1 / Eles	land 1		1	335	5653		131	22/	100	
1	30. Neme and address of person who	administration of death (the	am 23c) /3					12/	- 4/		
P	30. Name and address of person who	V		my )	21	921					
	31. Dete filed (Month, Day, Year)	32. Registrer's Sig									
State Registrar	, Day, Tom/	Jan 10 grantor a Gra	4	1							

DEC 2 7 2000

be & sparks

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month Yeer **Physician** 2000 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Nama (If not institution, giva street and number) Examiner PHALL GLENGES

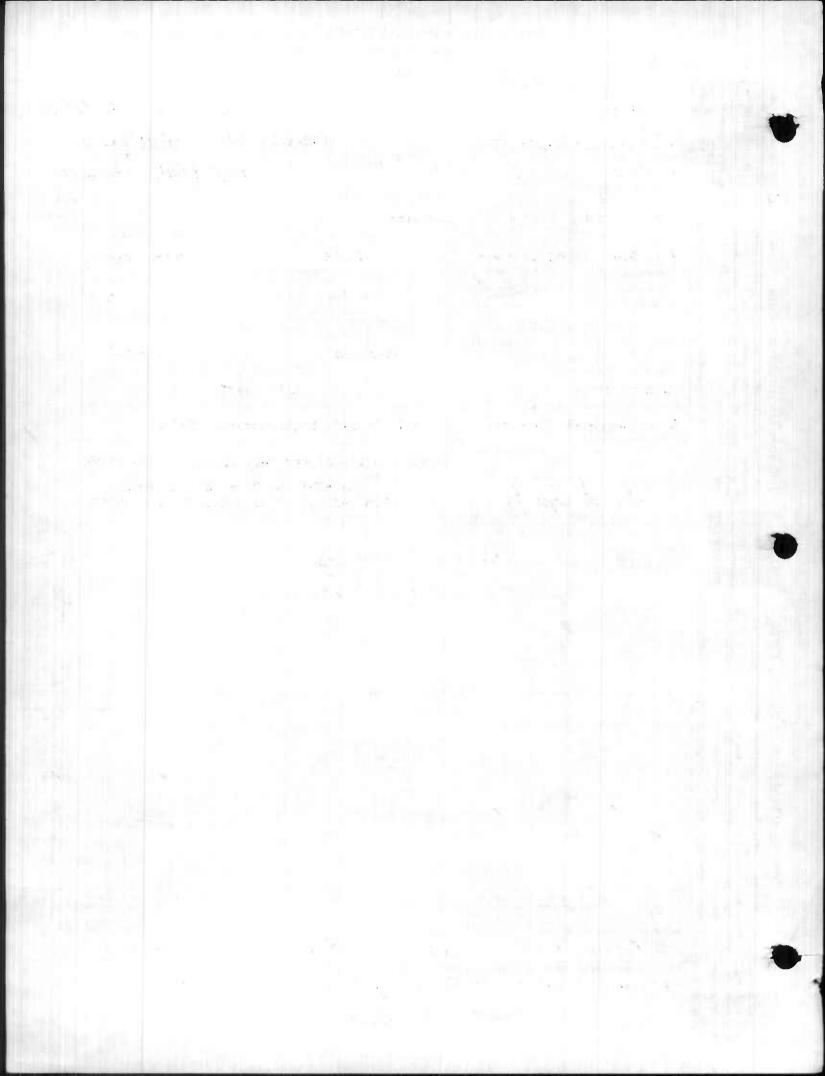
Birthplace (Stata or Foreign Country) Prince georges Assital Certe
5. Social Sacurity Number 6. Sex 7. Age week If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth 5. Social Sacurity Number 7. Age (In yrs. last birthday) **Funeral** 1□M 20 F Months Hours Days 85 579-38-7259 Yrs. Director Cheraw, SC Usual Rasidance of Decedant 4 1/3 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f ebor traumatic event, the Medical Examanar must be notified at Prince George 1 ¥ Yas 2 □ No MD Landover Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7916 Sherriff Rd 20785 United States death Funeral 14. Race - Americen Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 전 No If Yes, Giva Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 11. Merital Status 1 Naver Married 2 Married Maryland 21215-0020 1 Yas 2X No Specify: Specify: Black p 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decadant's Education (Specify only highast grada complated) d 2 should be filed within 72 th and Mental Hygiene. Elamentery/Sacondary (0-12) Collega (1-4or 5+) Homemaker Private 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be Jethro Davis Lily Davis 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informent's Name/Ralationship (Typa, Print) permit. Peges 1 and 2 st Department of Health and Important: if Itam 27 is n any Injury or other traun Ethel Campbell /Daughter 7916 Sheriff RD, Landover, MD 20785 Baltimore. 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 → Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Cemetery 12-29-00 Laurel, Md 22. Nama and Addrass of Facility
ALEXANDER S. POPE FUNERAL HOME 21. Signaturt of Funeral Service Licegoed 5538 MARLBORO PIKE, FORSTVILLE, MD 20747 23a. Part1. Entar tha disease, or complications that ceused the death. Do not antar the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Daath **Physician** /Medical tmmediate Cause (Final Intra Cranioll hemorh diseasa or condition rasulting in deeth) Examiner Examiner physician and s the buriel-trans Sequantially tist conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disease or Injury that initiated avants rasulting in death) Last Division of Vital Records, P.O. Box 68760, certificete be Physician/Medical Dua to (or es e consaquence of): 98 esn signed by the a 23b. Did tobacco usa contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 2 Unknown by 24b. Were autopsy findings available prior to completion of ceusa of daath? 24a. Was an autopsy Completed certificate has t 1 Yas 2 No 1 Yas 2 No funeral director, 25. Was cesa rafarrad to medicel axaminar? 26. Placa of Daath (Chack only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? 1 Naturel 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accidant after deat Director: 6 ☐ Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 6 24 hours a Hospital 29a. Certifier 1 Certifying Phyatcian: To the best of my knowledge, daath occurred at the time, date end plece, end due to the cause(s) and manner es stated. edical (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, In my opinion, death occurred et the time, data and place, and due to the causa(s) and menner stated. within 2 To the 29d. Data signed (Month, Dey, Year) 29b. Signatura and titla of certifian 29c. Licansa number Rointan Form hitan 12.24.00. D43446

State Registrar

ROINTAN FARAHIFAR 31. Data filed (Month, Day, Yaar) DEC 2 9 2000

.M.D. 9801 Georgia An Suit 3-35 SILVER SPRING MO 20902 32. Registrar's Signature

30. Nama and addrass of parson who complated ceusa of daath (Item 23e) (Type, Print)



#### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Year Helen Anna December 26, 2000 4e Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) FEB •:11, 19:18 7. Age (In yrs. last birthday) If Under 1 Year 5. Sociel Security Number 6 Sax 9. Birthplece (State or Foreign Deys Months Hours 10 M 20 F WASH. D.C. 82 578-12-1376 Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10e. State 10c. City, Town or Location MD. MONTGOMERY ROCKVILLE Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9701- VEIRS DRIVE 20850 USA 12. Wes Decedent Ever In U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11 Meritel Stetus Black, White, etc. 1 Never Merried 2 Merried WHITE 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementary/Secondery (0-12) Cottege (1-4or 5+) DIRECTOR OF NURSING MONTGOMERY COLLEGE 5+ 18. Mother's Neme (First, Middle, Maiden Sumeme) 17 Father's Name (First Middle Last) CLARA A. JACKLE JOHN C. STATTS 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 9825- VEIRS DR., ROCKVILLE, MD.20850 ALICE ROWE- SISTER 20e. Method of Disposition 20b. Plece of Disposition (Neme of Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCremetion 3 ☐ Removel from Stete METROPOLITAN CREMATORY-12/28-ALEXANDRIA, VA. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service bicensi 22. Neme end Address of Fecility Hysong Co., Inc. 6510 - 16th Street, NW, Wash, DC ed the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, 23a. Pert1. Enter the diseese, or cor shock, or heart failure. List only Approximete Intervel Between Onset end Deeth Immediate Cause (Finet disease or condition resulting in deeth) Preumonia Due to (or es a consequence of): Cell Carcinoma of the Lund uamous Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 24a. Wes en autopsy 1 Yes 2 No 1 ☐ Yes 2 PNo 25. Was cese referred to medicat exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 1 Meturet 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner stated. 29e. Certifier

attending physician and for use as the burial-transit The lew requires that the deeth certificate be exacuted P.O. Box 68760. the 6 signed b Division of Vitai Records, been si hes 36 2 eged certificate Physician: director, After this funeral di or Attending I Director: A id in by the fu deeth. after To the Hospital o within 24 hours at To the Funeral Di completely filled in

**Physician** 

/Medical

Examiner

Directo

Funera

by

the Medical

should be

Pages 1 and 2 s ment of Health an

Nepartment of Health reportant: If Item 27

**Physician** 

/Medical

Examiner

Examiner

Physician/Medical

by

Completed

Be

10

Certification:

(Check only one)

29b. Signeture end title of certifier

**Funeral** 

Director

5

Registrar

29c. License number D53244

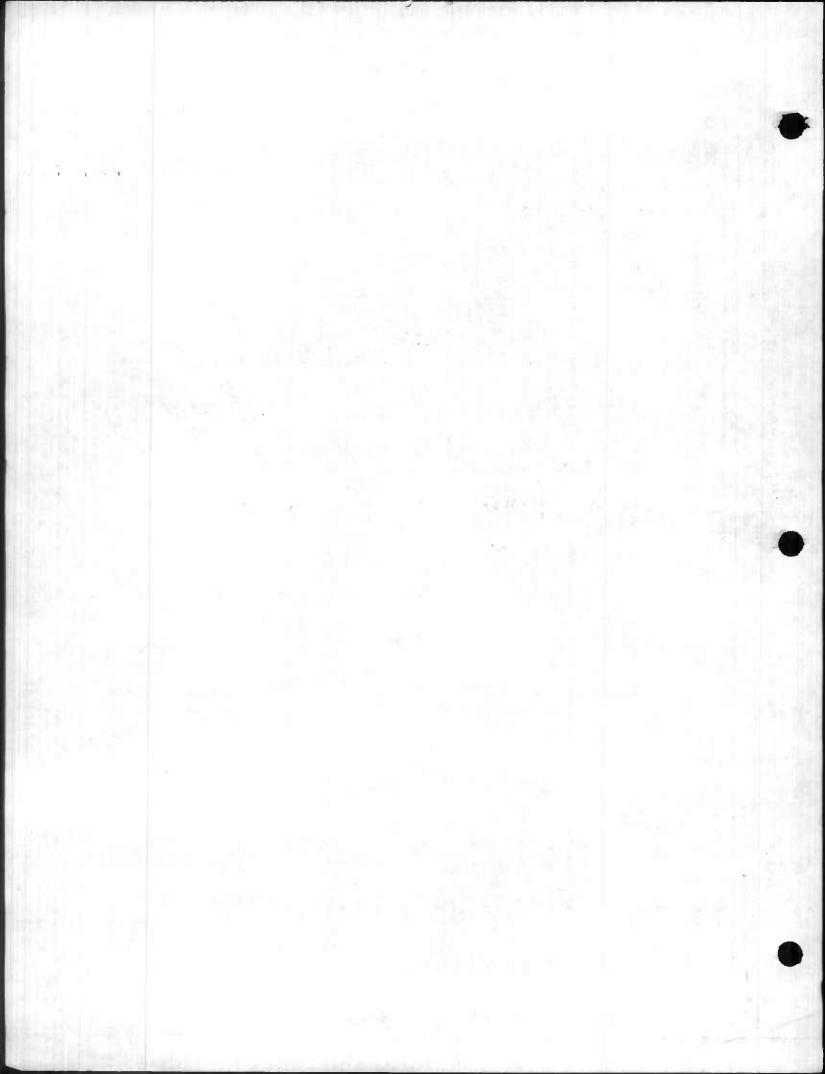
29d. Date signed (Month, Day, Year) December 26, 2000

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

Katharine R. Lillie, MD 11140 Rockville Pike, PMB 348, Rockville, MD 20852

31. Dete filed (Month, Day, Year) DEC 2 9 2000

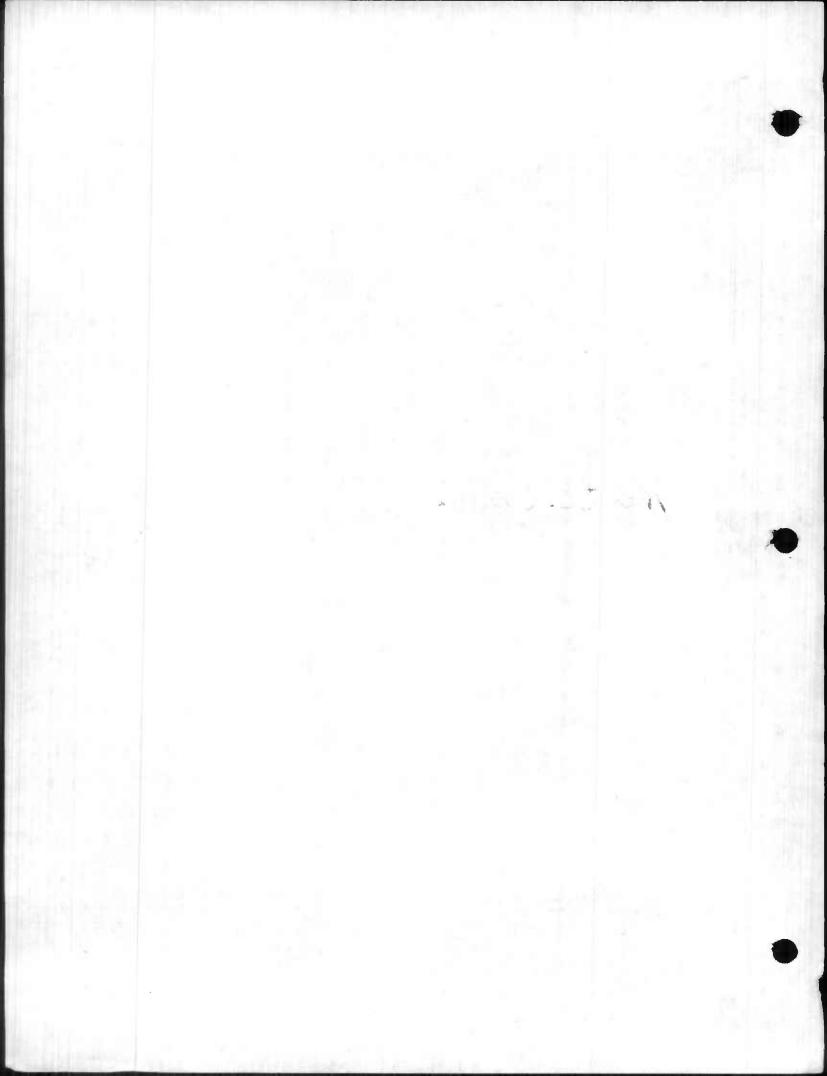
82. Registrar's Signeture



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Cert	ificate of	Death		Reg. No.	3 4	2330		
61	1. Decedent's Neme (First, Middle, Las	st)				2. Dete o		Yeer	3. Time of Deat		
Physician /Medical	Joan Kathryn	Shycoff					ember 21,		9:55 A.		
Examiner	4e Fecility Name (If not institution, give	street and number)			4b. City, To	wn, or Location of D	Deeth 4c. Coun	ty of Death			
	2921 Bradford L	ane			Bowie		Prin	ce Ge	orge's.		
Funeral	Social Security Number     6. S		last birthday)	If Under 1 Year Months Devs	If Under Hours	24 Hrs. 8. Dete o	f Birth b, Dey, Year)	9. Births	plece (State or Fore		
Director	031 24 3025	□ M 2423F 6	6 Yrs.	MOTRIIS Deys	Hours		29,1934		achusett:		
	Usuel Residence of Decedent										
How H	10e. Sfate 10b. County	10c. Cit	y, Town or Loc	ation					I Od. Inside City Lin		
to to	Maryland Prince Ge	eorge's B	owie						Yes 2□		
al', or Name 23a or 28a-f show Examinar must be inclined at by Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	Whet Cou	ntry?		
23a c	2921 Bradford Lane	2		207	15		United	Stat	es		
Jer Pa	11. Meritel Status	12. Wes Decedent Ever in U	,S. 13. W	as Decedent of I	lispanic Ori	gin? (Specify Yes o	r No- 14. R	ce - Americ			
5 E	1 Never Married 25 Merried	Armed Forces? 1 ☐ Yes 2 € No				n, Pueno Hican, etc.		ack, While,			
by by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Dates:	1	☐ Yes 2 No	Specify:		Spec	eity:	White		
2 E	15. Decedent's Ed	lucation	16e. Decede	ent's Usuel Occup	etion		16b. Kind of	Business/In	dustry		
Notice than "natural, the treatment of t	(Specify only highest gra		(Give k	ind of work done O NOT use retire	during mos d)	t of working	Congre	ssion	al-		
ther than	Elementery/Secondery (0-12)	College (1-4or 5+)	Secr	etary			U.S.				
To The Co	17. Fether's Name (First, Middle, Last)		Deel	ctary	18. Mothe	er's Neme (First, Mi	ddle, Maiden Sum	eme)			
atic ever To Be	John Flanagan					lma Hentz					
merke metic	19e. Informent's Neme/Reletionship (	19h Mailine	Address /Street	≓ um <i>ber, City</i> or Tow	n. State Zi	Code)					
Tie m treum	Donald B. Shycoff				Bowie Ma			,/			
other tra	20a. Method of Disposition						4		own, State		
of its	1 ☐ Burial 2 ☐ Cremetion 3 ☐	Hemovel from Stale		f Disposition (Name of ry, crematory or other place) Dec. 23, 2000 20c. Location - City					,		
Important: If flem 27 is marked other than "natural", any injury or other treumatic event, the Medical Exponent.  To Be Completed by	4 Donetion 5 Other (Specify) Metropolitan Crematory Alexandria										
ny in	21. Signature of Funeral Service Unapsee Robert E. Evans Funeral Home, Inc.										
5548	KOUNT C	. ( vam.				Road Boy			0715		
	23a. Pert1. Enter the disease, or com	olications that caused the deal	h. Do not ente	r the mode of dyi	ng, such es	cardiac or respireto	ory errest,	and	Approximete		
ysician	shock, or heart failure. List only	one ceuse on each line.						1	Interval Between Onset end Deet		
ledical	Immediete Cause (Final	Licers:	+			· Me	+ ++		3- 21		
aminer	disease or condition resulting in death)	0.			(0)	. //0	7/23/2/20	15	) 70.1		
ē		Due to (d	or es a consequ	ience of):				1			
an and rial-transit Examiner	Sequentially list conditions  Due to (or es a consequence of):										
al-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (d	or es a consequ	ience of):							
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physicia as the bur edical	resulting in death) Last	Due to (o	r es e consequ	ence of):				-			
č . 3		d									
igned by the attendir be detached for use by Physician/II											
the dispersion of the dispersi	Pert II. Other significant conditions of	ontributing to death but not res	ulting in the un	derlying cause gi	ven in Part	. 23b.	Did tobacco uss	contributa t	o the causs of de		
d by Setso							1 Y88 2 N	3 Pro	bably 4 Uni		
by by	VP							1			
should should leted						248.	Wes en eutopsy performed?	81	ere autopsy findir vailable prior to		
8 c C								of	ompletion of ceus deeth?		
te has sage 2							1□ Yes ऒNo	1	☐ Yes 2☐ No		
certificate irector, pag	25. Wes cese referred to medical				26 Plan						
director, page To Be Com	examiner?	Hospital:	ER/Outpation	3 DOA Ot	har:	1	of Death (Check only one) rsing Home 5 ☐ Residence 6 □ Other (Specify)				
ral dire	27. Manner of Deeth		28b. Time of	3LI DOA	4LINI		ribe how injury occ		19/		
al Director: After t led in by the funers Certification:	1 Neturel 5 ☐ Pending	28a. Dete of Injury (Month, Day Year)	Injury	28c. Inju Wo	rk? ]Yes 2□		and the second				
y the f	3 Suicide 6 Could not be		ome form stre				ion (Street and Nu	mber or Res	al Route Number		
into	4 Homicide determined	building, etc. (Specif	y) stre	et, rectory, office			r Town, State)		FIGURE FRANCES		
C S	20.001										
To the Funeral Director. After the completely filled in by the funeral Medical Certification:	(Check only 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examine									
Med Med	One)	and manner steted.		00-12-	00.000		204 D-4-	and /14	Day Manel		
200	29b. Signature and title of certifier	)		29c. Licen	se number		29d. Date sig	ned (Month)	Day, Year)		
	1 Cax	-		03	440	7	11/1	1/0	C-		
101	30. Neme end address of person who	completed cause of death (Iten	23a) (Type, P	rint)		101		,	. 20		
/	Dr Androus	Down 4	1751	VHar	1500	J (+#	2031	CUIT	omo		
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	7.75		- 110			7		
Registrar	31. Date filed (Month, Day, Year) DEC 2 7 2000	Serve	19 "	1							
registial	10 27 2000		14. M	pouls	/						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	anadenta Mama (Eliza Sart		771 1 30	D-OI WK.C	ertificate o	Death	10.0-1-10	Reg. No.	42999	
n .	Decedent's Name <i>(First, Midd</i> Ruth	E.		т	aylor		2. Dete of De Month	Day	Year 3. Time of Deeth	
	Facility Name (If not institution		nd number)	1	aytor	4b. City. Town	DECEM , or Location of Deat	BER 22,	2000 1924P.M. of Death	
	050 WEST PERI		,	Im Grova Me	edical Cent				E GEORGES	
	ocial Security Number	6. Sex 1 ☐ M 2 反	7. Age (II	n yrs. Iast birthde ວ່ວ	Months Dey	11 011061 24	Min (Month, De	rth ey, Year	9. Birthplace (State or Foreig Country) Cartlage, NC	
	238-20-7153			0.5 Yrs.			January	1, 1917	Cartlage, NC	
-	. Stata 10b. County	у	10	c. City, Town or	Location				10d. Inside City Limits	
	District of	f Columb	pia	Wash	ington				1 ☐WYes 2 ☐ No	
10e	. Street and Number	L COTAIN	-	,,,,,,	10f. Zip Code	535		10g. Citizen of V	What Country?	
9	933 - L Street	t, N.W.	#106		2000	01		United	States	
11.	Marital Status	12. Was	Decedent Eve	r in U,S. 1	3. Was Decedent of	Hispanic Origin	? (Specify Yes or No Puerto Rican, etc.)	o- 14. Rac	e - Americen Indian, ck, White, etc.	
	1 Navar Merried 2 Ma	rried 1 🗆 '	Yes 2√ No s, Give		1□ Yes 2□N			Specify		
	3 Widowed 4 □ Divorce	d Year	r or Datas:			1000				
	(Specify only highs	nt's Educetion ast grade comple	ated)	(Gi	cedent's Usual Occ va <i>kind of work d</i> on o. <i>DO NOT</i> use <i>reti</i> i	e durina most o	f working	16b. Kind of Bu	usiness/Industry	
- 4	lementary/Secondary (0-12)	Colle	ege (1-4or 5+)		Domest:			Private		
17. Father's Name (First, Middle, Last)						_	Name (First, Middle	ddle, Maiden Sumeme)		
Alton Harvey						Bertha (Unknown)				
	a. fnforment's Name/Relation Audrey Gavins							tural Route Number, City or Town, State, Zip Code) #106 Washington, D.C. 20001		
	. Mathod of Disposition	- Jaagi		20b. Place of Dis	sposition (Nema of					
	1 ☐ Buriel 2 ☐ Cremation			cemetery, c	rematory or other p		1/2/2001		and, Maryland	
-	4 Donetion 5 Other (	1		The second second			_			
	Maku Le	1/1	10.0	THE	4001 -	tosa of Facility	Stewart Fu	neral H	ome, Inc.	
23	Part1 Entar tha disease, o	or complications t	that caused the	death Do not			., N.E. Wa		Approximete	
4.00	show, of heart failure. Lis	t only one ceuse	on each line.	Geath. Do not	anter the mode of d	ying, such as co	rollac of raspiratory e	irrast.	Interval Between Onset and Death	
	medlete Ceuse (Final		TIIN	G CANCER						
res	ease or condition ulting in death)	a		e to (or es a cons	sequence of):		•		1	
3				0 10 (0. 00 0 00	oqualios oi).					
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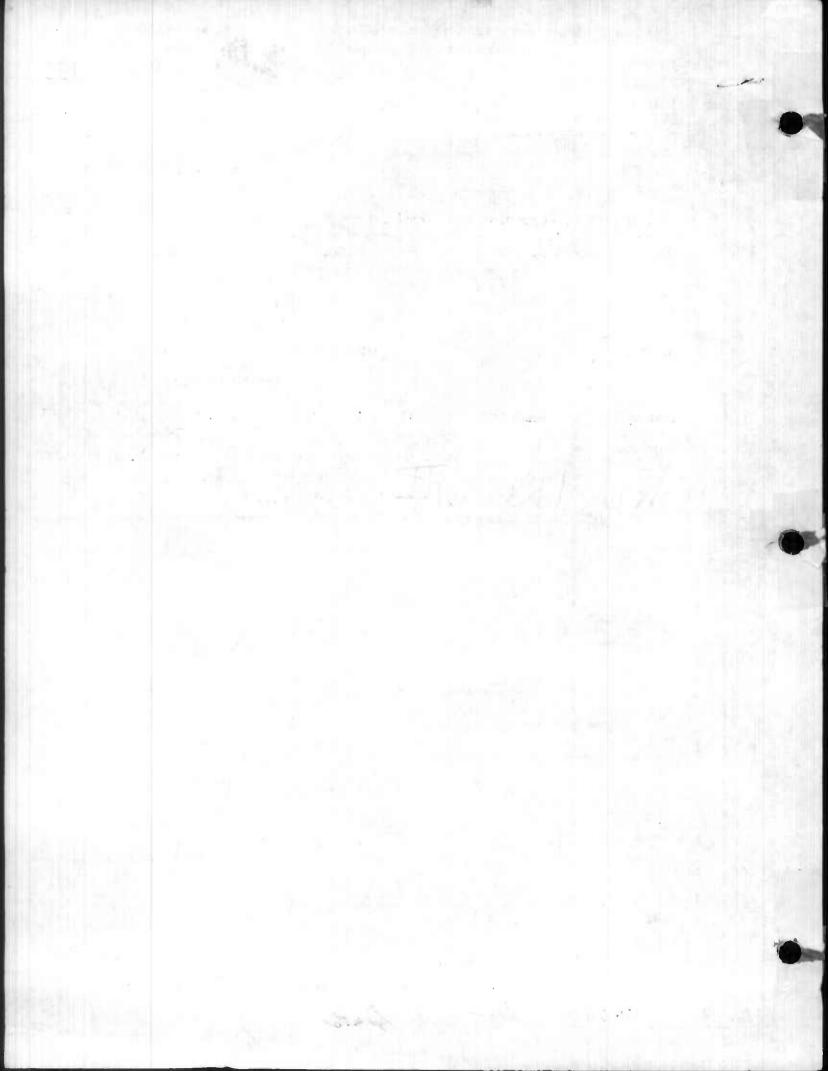
Registrar

JAN 0 3 2001 Serve

gistrar's Signature

G. Aparla

ORIGINAL



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day **Physician** Jennifer Ann Trozzo 8:20 am December 28, 2000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Yaar | If Under 24 Hrs. | Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dev. Year) **Funeral** 1□M 20 F Months Deys Hours Min. Yrs. 48 215-60-8088 Director Aug. 9, 1952 Maryland Usuel Residence of Decedent with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 238 4012 Van Buren Street 20782 Funeral filed within 72 hours after deeth 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ऒ No If Yas, Giva Yeer or Dates: Reme 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Merital Stetus Black, White, etc. 1 ☐ Never Married 2 N Married 21215-0020 8 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White "naturel". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry el Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Beauty Salons permit. Peges 1 and 2 should be filed to bepartment of Health and Mentel Hygie Important: if item 27 is marked other than Injury or other traumatic event, the page. 12 Hair Dresser Baitimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Meiden Surnama) Be Adolph Nelson Patricia Jean Booth Mason 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen P. Trozzo - Husband 4012 Van Buren Street, Hyattsville, MD 20782 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 12/29/00 Alexandria, Virginia 22. Name end Address of Fecility
Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. 4739 Baltimore Avenue, Hyattsville, MD 20781 Approximete Intervel Between Onset end Death Physician PIRATION PREUMONIA Immediete Ceuse (Final disaase or condition resulting in death) /Medical RECURREN **Examiner** MULTIPLE SCLEROSIS Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): use as the Box ( P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uas contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 by of Vital Records, 24b. Ware autopsy findings available prior to completion of cause of deeth? page 2 should Be Completed 24a. Was an eutopsy performed? hes 1 Tas 20No 1 □ Yas 2 □ No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifies 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) edical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Menger of Deeth 28b. Time of 28d. Describe how injury occurred Division 1 Neturel 5 Pending Injury 1 Yes 2 No 2 Accident Investigation 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide to Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the ceuse(s) end menner steted. 29a, Certifier completely 29d. Dete signed (Month, Day, Year) 29b. Signeture and Ittle of certifier 0

DHMH 16 Rav 6/95

State

Registrar

31. Date filed (Month, Dey, Year)

DEC 2 9 2000

32. Registrer's Signeture

